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Exploring tentativeness: risk, uncertainty and ambiguity in first time pregnancy

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Abstract

This thesis explores fifteen women's accounts of pregnancy over the course of gestation. It highlights the fluidity and dynamism of these women's experiences, placing these in the context of the breadth of medical interventions they engaged with. Much existing literature concerning pregnancy focuses on specific instances of contact with medical professionals or technological interventions. This study explores the mundane and routine elements of the everyday practice of pregnancy, including during the first trimester. This is a period rarely addressed in academic literature.

The thesis draws on data from in-depth interviews with women in Scotland, experiencing a continuing pregnancy for the first time. These were conducted at three points over the course of gestation. Interviews aimed to explore women's interactions with medical interventions, their conceptualisations of the foetus, and changing experiences of embodiment. Analysis took place in several stages, incorporating three 'readings' of interviews and the development of a case study for each participant. This was inspired by the voice centred relational method of analysis. Themes were then identified and developed within, and between, individual women's accounts. Participants' narratives, particularly in early pregnancy, resonated with Rothman's (1988) concept of the 'tentative pregnancy', originally developed to describe pregnancy in the wake of amniocentesis. Tentativeness emerged as a key theme characterising women's experiences.

Tentativeness was especially evident during the first trimester, largely due to women's understanding that the risk of miscarriage was at its highest during this period. Women described managing their emotions at this time, in order to balance excitement about their wanted pregnancy with the possibility that it may end in a pregnancy loss. One aspect of this emotion work, explored in this thesis, was the effort made by women to keep their pregnancy a secret from wider family and friends for the first twelve weeks of gestation.

Medical intervention and its associated technologies played a key role in both constructing pregnancy as tentative, but paradoxically, also provided a means to resolve this through reassurance. Women engaged with these interventions flexibly. In contrast to much existing literature, this thesis highlights that while contact with prenatal technologies cemented the reality of the pregnancy for some, they also had the power to add to the ambiguity of participants' status as a 'pregnant woman'.

In later pregnancy, women's shifting embodied experiences contributed to a reduction in tentativeness. The ability to feel definite foetal movements, coupled with medical and popular discourses of foetal viability, allowed women to feel less anxious about the safety of the pregnancy and the foetus. As a result, women reported changed interactions with health professionals and advice during the final trimester of pregnancy.

This thesis, engaging with literature from sociology, science and technology studies (STS) and anthropology, makes theoretical contributions in three areas. First, its consideration of gestation over time nuances discussions of pregnancy in terms of risk. Second, this research further contributes to literature regarding pregnant embodiment, and conceptualisations of the foetus. Third, the thesis demonstrates that relationships between forms of knowledge mobilised by participants during pregnancy were complex, shifting over the course of gestation, and reflective of women's experiences of pregnancy as tentative.

Declaration

I declare that

- (a) this thesis has been composed by myself
- (b) the work presented in this thesis is my own
- (c) this work has not been submitted for any other degree or professional qualification

Emily Ross

March 2015

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Key to transcriptions

Quotes from participants are italicised

Bold text in participants' quotes indicates author's emphasis

Underlined text in participants' quotes indicates a participant's emphasis

“...” indicate where text has been omitted from a quote.

Chapter One

Introduction: Exploring experiences of pregnancy

1.1 Introduction

The nine months of pregnancy encompass unique and at times dramatic changes to a woman's body, having the potential to affect her emotions (Warren and Brewis, 2004), and her relationships with others (Draper, 2003). The changes observed in pregnancy thus have implications for individual women, but also for their social networks, and more widely, for the social sciences. This thesis draws chiefly on medical sociology to explore fifteen women's experiences of a first time pregnancy¹. These women's pregnancies were typical, in terms of their circumstances and management, of many others in the UK today. My participants were aged between 26 and 38, were married or had partners, and were all experiencing medically uncomplicated pregnancies.

Using qualitative interviews, this study aimed to explore these women's accounts. It sought to document the fluidity and diversity of experiences within a group of seemingly homogenous and 'ordinary' pregnancies, tracking these over time. My research also aimed to examine the early stages of pregnancy, a period of gestation rarely discussed in existing literature. As integral aspects to the experience of pregnancy for many in the UK today, this thesis inevitably considers the various technologies and interventions engaged with by my interviewees as part of their antenatal care. These shaped women's conceptualisations of the foetus, and perceptions of risk to their pregnancy. My participants' accounts are outlined in the

¹ Though one of my participants disclosed that she had experienced miscarriages in the past, I did not ask participants about this, nor did I ask about experiences of a termination. I therefore cannot say with certainty how many interviewees were experiencing pregnancy for the first time. To account for the fact that participants may have experienced (the early stages of) pregnancy in the past, I use 'first time pregnancy' in the sense that the pregnancy under discussion was the first (expected or hoped) to continue to full term.

following chapters, with their experiences at times complicating the claims and assertions of existing literature.

This thesis also documents the realities of using qualitative methods. The process of qualitative research can be unpredictable, at times leading researchers in new directions. Exemplifying this volatility, the initial research aims and questions shaping this study were reformulated following some of my early interviews. I outline this shift below, presenting a small extract from my qualitative interviews with women experiencing pregnancy for the first time.

This introductory chapter briefly situates my work within existing literature, before going on to describe how my initial research focus was re-shaped in response to the accounts of pregnancy given my participants. The chapter finishes by outlining the remainder of the thesis.

1.2 Academic engagement with pregnancy: the turn to the ‘everyday’

Social science literature considering pregnancy represents a considerable body of work. Discussions of pregnancy are found within several disciplines including anthropology and sociology, as well as psychology. These engage with pregnancy at both macro and micro levels, with the former largely comprising of work on the medicalisation of pregnancy and childbirth (e.g. Oakley, 1984). This includes discussion of the choices and dilemmas for women created by prenatal diagnostic technologies (Rapp, 1999), and assisted reproductive technologies (Becker, 2000). Micro level studies have considered topics such as material consumption during pregnancy (Taylor, 2000), and efforts made by women to communicate with the foetus (Han, 2009a). These debates are explored further in Chapter Two.

Studies of these more intimate and individualised experiences of pregnancy contribute to a recent call for attention to what have been called the ‘mundane’ practices of everyday pregnancy (Han, 2013). Han notes that despite being characteristic of the majority of women’s experiences, existing literature in the field of pregnancy and childbirth has long neglected experiences of ‘ordinary’ pregnancy.

This she defines as pregnancies that are “more or less normal, healthy and uncomplicated” (2013: xi). Indeed, Ivry (2010: 263) notes that anthropologists in this field have tended to focus on “reproductive dramas”. These include the medical management of childbirth (Davis-Floyd, 1992; Davis-Floyd and Sargent, 1997), pregnancy loss (Layne, 2003; Cecil, 1996), and to a lesser extent pregnancy termination (Clarke and Montini, 1993; Gerber, 2002). This, Ivry argues, neglects the ongoing processes of gestation. Further, focusing on pregnancy in this way too often attend to *representations* of the pregnant body produced by technologies, as opposed to the pregnant body itself (2010: 263). Ivry thus recommends a departure from anthropological studies focusing on instances of medical intervention, calling for research that places pregnancy, and not technology, at its centre.

Acknowledging these criticisms of existing work, this thesis considers some of the everyday practices of pregnancy. The qualitative interviews on which it is based were conducted with women experiencing ‘low risk’ pregnancies. My participants were enlisted into a routine schedule of care, involving contact with minimally invasive technologies such as blood tests and ultrasound scans². The chapters that follow touch on many of these routine interventions, but also examine the embodied and emotional aspects of pregnancy.

The interviews conducted for this study took place over a period of eleven months, between November 2012 and October 2013. They explored fifteen women’s accounts of pregnancy at three points during gestation. The qualitative approach embraced by this research allowed for rich exploration of participants’ experiences, with recognition of the social and material contexts in which these took place (Mason, 2002: 62). This is described further in Chapter Three. However, my approach also entailed challenges and unexpected outcomes, both in terms my research practice, and to my initial conceptualisations of the phenomena under study. The next section describes how I came to conduct this research, but also how my

² Nevertheless, despite all being labelled as having medically uncomplicated pregnancies, my participants underwent an array of experiences, including several incidents of ‘drama’. For interviewees these included trips to the hospital for suspected ‘broken waters’, ongoing heavy bleeding, one visit to hospital following a fall, and a case of severe back and pelvic pain.

participants' initial stories led me away from my original research questions, to new research aims.

1.3 Conceiving my research focus

Reflexivity is an integral element of this research. Attention to my role in the generation, selection and analysis of data, and thus the entwinement of these with my biography, is important to the transparency and accountability of my work (Finlay, 2002a: 211). This is discussed further in Chapter Three, and reflections on my part in the research process appear throughout the remainder of this thesis.

The research reported here arose from an interest in the concept of maternal-foetal bonding. I became interested in the proposition that women experience a bond with the foetus they carry whilst researching women's engagement with antenatal health advice (Ross, 2012). During this research, conducted for a postgraduate degree in public health, I was struck by the assumptions written into some of the guidance women receive during pregnancy. Public health discourses regarding healthy behaviours during pregnancy often draw on an imperative to safeguard the foetus, depicting the foetus as vulnerable and in need of protection (Oaks, 2001; Lupton, 2012). Implicit within much of the health advice appealing for women to protect the foetus are moral discourses of mothering, maternal-infant attachment, and maternal responsibility (Bell et al., 2009).

In the early research described above, I explored whether the concepts of attachment (or 'bonding') and protecting the foetus, harnessed by some sources of antenatal health advice, resonated with women's experiences of pregnancy. The women I interviewed for this initial project largely complied with the antenatal advice they received, providing explanations in line with the logic described above. Protecting the foetus and ensuring a healthy baby were frequently given as reasons for abstaining from alcohol, or from the foods advised against during pregnancy (see NHS Health Scotland, 2012 for examples). Women articulated feeling close to the baby within them, which some expressed in terms of a bond. They described reflecting on this emotional connection when considering whether to drink alcohol,

or consume foods advised against in the health advice they received (Ross, 2012). The original motivation for this thesis was thus to explore any experiences of such an emotional connection with the foetus over the course of pregnancy, and how this might be created. However, my early interviews for this PhD prompted me to re-think my initial understandings of my research topic. This is reflective of the nature of qualitative research, which as described by Mason (2002: 24) is characteristically fluid, flexible and data-driven.

After having completed pilot work and reviewing literature for the research on which this thesis is based, I began my in-depth interviews with women in early pregnancy, to seek participants' descriptions of a maternal foetal bond. However, during my interviews taking place during the first trimester of pregnancy, and for some shortly after, I noted that women's accounts pointed to the 'abstract' and 'unreal' nature of this point of gestation, and with regards the presence of a foetus. This is best illustrated by Sinead, the first participant to be recruited into my study.

Responding to heightened estimations of miscarriage risk during the first trimester, I had decided to wait until participants had undergone a twelve week scan before asking about what experiences of a 'bond' might be like during pregnancy (this decision is described further in Chapter Three). During her thirteenth week of gestation, I interviewed Sinead for the second time. My questions initially focused on the more general and mundane aspects of pregnancy, such as telling others the news, and experiences of pregnancy symptoms. My final questions, however, were designed to elicit accounts of what I understood to be a bond. Making sure not to use this term myself, nor to directly refer to the foetus so as to be guided by my participants' conceptualisations of the entity within (see Chapter Three), I looked to Sinead, following a discussion about her recent twelve week ultrasound scan, and asked the question driving my research project:

Emily: Do you have any feelings towards what it [the foetus] is, what it is at the moment?

Sinead: um, i.e. if it's a boy or a girl, or what it will become?

Emily: what it is now, like looking at the [scan] picture

Sinead: well if you'll notice it is on the picture rather than me looking gazing into where it actually is located, it's quite strange but. What it is now?

Sinead seemed confused by my question, and I thus tried (a little clumsily) to rephrase it:

Emily: well you know like mothers, and fathers, like love their babies, do you like feel like, love or something, towards what it is?

Sinead: do I feel love towards what it is?

Emily: does that make sense?

Sinead: I don't know. It's a funny thing. Maybe, it can only exist in my stomach right now though. That's maybe what's sort of. Ah, I dunno. I think if I was to have a miscarriage it would be upsetting. I can't really say whether it would be, if I love it, because it is still fairly abstract.

Unlike participants in my earlier study, my questions regarding a bond or similar emotional connection made little sense to Sinead. I realised that this was because the entity within her, during her thirteenth week of pregnancy, was distinct from that discussed in the research project described above, during which time my participants were in the later stages of pregnancy, or had already given birth.

After having been critical of the assumptions embedded within antenatal advice, I realised that I myself had brought my own assumptions into the research process. I had presumed that, whether some form of bond was present, absent, or in flux, the foetus would be conceptualised by women as an entity to which they *could* (potentially) bond. I had not taken into account that such an entity may in fact not exist for women. When interviewing Sinead during this stage of pregnancy, the foetus for her was 'abstract', an 'it', and thus something difficult or impossible to form what I had understood as a bond with.

I wrote about this incident, as well as the abstract nature of early pregnancy as expressed by other participants, in my research diary. After reflecting on the matter

for several days, I came to the conclusion that before I could explore women's experiences of a so-called bond with the foetus, I first had to try and understand how women conceptualised the foetus. From Sinead's account, it seemed that this might be as something ambiguous or indescribable. I thus broadened my research aims, deciding instead to explore women's changing experiences of pregnancy and the foetus over time, in the context of the breadth of medical interventions and technologies they engage with (see Chapter Two for a more detailed outline of my research aims). Such an approach would allow not only for the presence of a foetus, but also its absence, and anything in between.

A key finding of this thesis was that women's understandings of the foetal entity were in part shaped by their perceptions of how likely the pregnancy was to end in a baby. I found that these experiences resonated with Rothman's concept of the 'tentative pregnancy' (1988). This is explored in the chapters that follow.

1.4 Structure of thesis

This introductory chapter has briefly sketched the academic context in which this thesis is situated, before describing how I came to (re-)formulate my research focus and aims. As described, these shifted at an early stage of my research, in response to the initial accounts given my participants.

Chapter Two presents an overview of existing debates within the social sciences surrounding the topic of pregnancy. At times these have mirrored broader theoretical concerns. For example, early academic engagement with the medicalisation of pregnancy reflected feminist discussions of masculine bias within the sciences more generally. More recent work has described the conceptualisation of the foetus as already a 'person', along with the consequences of this for women's reproductive rights, and experiences of embodiment during pregnancy. However, there is a lack of literature exploring experiences of pregnancy over time, and also of literature considering personal accounts of early pregnancy.

Chapter Three outlines the methodology used in this research. Arising within an interpretivist paradigm, but with a focus on material (pregnant) bodies, this research broadly aligns itself with a critical realist ontology (Williams, 1999; Maxwell, 2012). This allows for the acceptance of a reality outwith perceptions and representations of it, whilst acknowledging that this reality can only be accessed through partial and situated accounts. The chapter outlines the rationale for my use of qualitative interviews, and the various methodological influences on this thesis, which include feminist and narrative approaches. I also briefly describe a pilot study conducted prior to longitudinal interviews, and how this informed the choice of sample, topic guides and timing of interviews conducted for this research. Finally, I outline my analytical approach. This drew on methods inspired by the ‘voice centred relational method’ of analysis, described by Mauthner and Doucet (1998).

An ‘Interlude’ then provides brief descriptions of my fifteen interviewees. Though demographically similar, these fifteen women gave diverse accounts of their reproductive histories, and also of their paths to pregnancy.

Chapter Four describes these women’s experiences of early gestation. This is defined in this thesis as the first twelve weeks of pregnancy. During this stage, my interviewees articulated anxiety with regards the perceived risk of pregnancy loss. Their perception of early pregnancy as ‘risky’ was shaped by discourses regarding miscarriage received from medical sources. These were substantiated by their uncertain embodied experiences at this time, and knowledge of stories of pregnancy loss amongst family and friends. These accounts of early pregnancy resonated with Rothman’s (1988) notion of the ‘tentative pregnancy’; a concept she uses to describe women’s experiences of pregnancy in the wake of amniocentesis. Echoing the tentative pregnancy, interviewees described feeling ‘in limbo’ during early pregnancy, caught between being a pregnant and non-pregnant woman. They used various methods of managing this uncertainty, including emotion work (Hochschild, 1979). The chapter also discusses women’s experiences of conception, which echoed the tentativeness of early pregnancy.

Chapter Five describes interviewees' conceptualisations of the foetus. For the majority of interviewees, the foetus was an ambiguous entity during approximately the first twenty weeks of gestation. I argue that this was in part due to the fact that at this time, in the absence of foetal movements, the foetus was accessible only through its (technological) representation. I describe three ways in which the foetus was accessible to women prior to the sensation of movements: pictorial representations of fetuses, the ultrasound scan, and the foetal heartbeat Doppler. The chapter highlights that though technologies such as the ultrasound scan are often described as cementing the reality of pregnancy for women, they also had the potential to further add to the ambiguity of my interviewees' status as a pregnant woman. Participants engaged with such technologies in varying ways over the course of their pregnancy. This was in part shaped by with how far they wished to attribute personhood to the foetus, and in response to their experiences of pregnancy as tentative.

Chapter Six largely describes the final trimester of pregnancy. At this time, participants' bodies had taken on a recognisably pregnant shape, and foetal movements had become a regular occurrence. These embodied experiences accorded with medical discourses of foetal 'viability' during the later weeks of pregnancy. This is a term used to describe of the ability of a foetus to survive should it be born prematurely. Though familiar to my interviewees, the concept has been little studied in social scientific literature. Women valued the sensation of foetal movements as evidence of the presence and safety of the foetus. Their accounts challenged literature claiming that women's bodily experiences have become devalued by technological intervention in pregnancy. By this later stage of pregnancy, the majority of narratives I heard were no longer characterised by 'tentativeness'. This had implications for women's interactions with medical professionals and advice at this stage of gestation. Some interviewees described being more relaxed with regards antenatal advice and recommendations they received.

The final section, Chapter Seven, presents a discussion, highlighting the theoretical contributions made by this thesis. This research has nuanced discussions of pregnancy in terms of sociocultural theories of risk, by drawing upon related

concepts of uncertainty and ‘tentativeness’. By outlining women’s conceptualisations of the foetus as an ambiguous entity, both apart from and through medical technologies, it has also added to debates regarding the construction of the foetal subject. Contributions to theoretical discussions of pregnant embodiment have also been made, through descriptions of women’s experiences of bodily (and foetal) absence (cf. Leder, 1990). Finally, the thesis has described the complex interactions between various forms of knowledge engaged with during pregnancy, reflecting their experiences of pregnancy as tentative. This research demonstrates that the notion of the tentative pregnancy (Rothman, 1988), originally developed to describe pregnancy in the wake of amniocentesis, is a useful concept through which to explore women’s experiences of first time pregnancy. This is followed by a brief conclusion in Chapter Eight. This chapter presents factors to consider before attempting to extrapolate from my findings, and with these in mind, explores the implications of my thesis for future research.

Chapter Two

Literature Review

2.1 Introduction

Though commonly associated with Women's or Gender Studies, academic engagement with pregnancy has also made important contributions to wider social scientific debates. The subject has added to theoretical discussions of, but not limited to, the body and embodiment, technology, and the profession of medicine. This review outlines major work in the field of pregnancy, drawing on literature from sociology, science and technology studies (STS) and anthropology. This will provide context for the qualitative research reported in Chapters Four, Five and Six.

In what follows, I outline three major areas of study regarding pregnancy, beginning with a historical overview of the assimilation of pregnancy into the medical domain in Section 2.2. The charting of the movement of pregnancy from the hands of non-professional female midwives into those of trained medical practitioners arose largely from feminist work in the late twentieth century. Some commentators at the time conceptualised the medical management of pregnancy as contributing to the social control of women, discussions of which arose in tandem with feminist debates outlining masculine bias in technoscientific practices more generally (e.g. Harding, 1986). I will discuss some of these arguments, and also outline more recent approaches to the situation of pregnancy in the medical domain, which often draw upon sociocultural theories of risk.

Section 2.3 outlines another major stream of debate within academic discussions of pregnancy: the emergence of the 'foetal subject'. This is linked both to the use of visualisation technologies in prenatal care, and to the construction of pregnancy as in need of particular management to safeguard the foetus, often depicted as vulnerable

and in need of protection. I outline discussions, again largely from feminist standpoints, which document the history of the emergence of the foetal subject, and also anthropological perspectives which demonstrate its cultural contingency. I also introduce viewpoints from clinical research, which, related to the emergence of the foetal subject, often depicts the foetus as an entity to which women can be emotionally attached or bonded.

In the final part of this review, Section 2.4, I briefly describe the sociology of the body and embodiment, providing important context for contemporary approaches to the study of pregnancy. These more recent discussions often focus attention to the pregnancy experiences of individual women. This shift has followed an appreciation that experiences of pregnancy in their own right, outwith the context of medical interventions or the creation of the foetus as person, are amenable to theoretical discussion.

Existing literature has at times discussed interventions experienced in pregnancy *and* childbirth in the same terms. I argue that these are distinct experiences, and as such the interventions experienced by women hold different meanings. They thus merit separate discussion. The same is exhibited with work incorporating considerations of assisted reproductive technology *and* prenatal diagnostic technology. Again, these are experienced by women in different contexts and provoke different concerns. This literature review aims to make a clear distinction between these varied phenomena. Childbirth is discussed only in Section 2.2, due to the fact that early feminist debates on this topic were a precursor for much of the literature contained in this review. The remainder focuses specifically on social science-based accounts of gestation, and largely on technologies experienced as part of antenatal care.

2.2 Situating pregnancy in the medical domain

The experiences of the research participants in this thesis were shaped by the fact that they experienced a regime of prenatal care offered by medical institutions and clinically trained professionals. Though characteristic of women's experiences of pregnancy in the UK, the understanding of pregnancy as a medical matter has a

specific history, and has been widely critiqued. In this section, I provide a sketch of the literature describing the incorporation of pregnancy into the medical domain, before outlining more nuanced discussions of the medical management of pregnancy in contemporary scholarship.

2.2.1 Medicalisation in sociology

Analyses of medicalisation, the pathologisation of diverse facets of human experience, and their management under medical influence and supervision (Zola, 1983: 295), constitute a significant area of study within the sociology of health and illness. In early examples of these debates, Conrad and Schneider (1980) describe the mechanisms through which behaviours once understood in terms of deviance, such as addictions, came to acquire the status of sickness. Shifts in the classification of these experiences did not just depend on enhanced understanding of conditions or improved treatments, but efforts to transform the conceptualisation of behaviours or experiences as medical, and the acceptance of these conceptualisations by others (Foucault, 1989). For sociologists, interest lies in the processes through which certain conditions or behaviours come to be described as medical issues, and how this transforms everyday experience – for example through altering understandings and definitions of acceptable bodies and behaviours (Conrad, 2007). Accounts of medical professionals as holding authority over the right to define and treat illness, in which diagnosis plays an important role (Jutel, 2009), and of the transformation of patients into objects through the clinical ‘gaze’ (Foucault, 1989), have led theorists to argue that the medical profession is a powerful agent of social control (Zola, 1972; Conrad, 1992).

Contemporary sociological discussions have taken a more nuanced approach to medicalisation, turning their attention to the diffuse nature of power relations and mechanisms of resistance (Pickett, 1996), and also to the co-production of medicalisation processes through networks of actors including researchers, practitioners and patients (Clarke et al., 2010; Pickersgill, 2012). Both of these positions are demonstrated further below in relation to the medical intervention engaged with by women during pregnancy. First, it is useful to outline a brief

(situated) history of the medicalisation of pregnancy and childbirth, which provides a backdrop to the medical intervention women, including the participants in this research, receive in the UK today.

2.2.1.1 The medicalisation of pregnancy

Oakley (1984) explains that before the nineteenth century, antenatal care was limited to advice on lifestyle, and non-invasive techniques such as abdominal palpitation, should a woman seek a doctor's assistance during pregnancy (1984: 25). Institutional antenatal care, however, soon followed the introduction of 'lying in' hospitals (providing a space for women to rest following birth) in the eighteenth century (Wertz and Wertz, 1977). These facilitated the movement of pregnancy and childbirth into the medical domain, specifically the emerging profession of obstetrics, and contributed to the depiction of childbearing as potentially pathological (Oakley, 1984: 29). Oakley argues that the discovery of new therapies and monitoring techniques played an important part of the history of antenatal care and assistance during labour. Donnison (1988: 34) agrees, attributing the rapid acceleration of the management of birth from female attendants, into the jurisdiction of male practitioners, to the introduction of forceps in the eighteenth century. The ready acceptance and use of such technological aids to assist women during birth has been seen as according with dominant cultural metaphors of the time, including the conceptualisation of the body as machine (Davis-Floyd, 1990), but also with depictions of the female body as physically frail and intellectually weak. This further legitimised the need for mechanical assistance during labour (Martin, 1989), but also women's exclusion from medical practice (Schiebinger, 1987; Jordanova, 1989).

Oakley credits the movement of pregnancy itself into the care of medically trained professionals, which followed increasing numbers of women giving birth under medical supervision by the early twentieth century in Britain, to the singling out of childbearing as an activity of concern to the state. She asserts that this represented a move to tackle early infant death by educating mothers in infant care, and by the end of the First World War, to reduce maternal mortality (Oakley: 1984). Women were encouraged to seek assistance through resources such as advice manuals, which

provide early examples of the emphasis on risk during pregnancy. These also demonstrate that the positioning of women as morally responsible for mitigating risk in pregnancy, discussed further in Section 2.2.3.1, is not recent phenomenon (Hallgrimsdottir and Benner, 2014). By the 1960s, and following the formation of the NHS, institutional antenatal care was well established. However, it was “revolutionised” (Oakley 1984: 155), with the introduction of the routine use of technologies as part of this care, most notably ultrasound.

The next section describes debates surrounding some of these technologies, which have largely arisen from feminist scholarship. Most relevant to this thesis are those regarding the technologies experienced routinely as part of antenatal care, though I shall also draw on discussions of assisted reproductive technologies (ARTs). This literature provides important context for the research that follows.

2.2.2 Feminist accounts of technology and pregnancy

Early feminist accounts of the application of reproductive technologies to women’s bodies in the 1980s were most visible in relation to the emerging reproductive technologies of assisted conception. These included in vitro fertilisation (IVF), and techniques enabling surrogacy. Such accounts often depicted technology as a tool of patriarchal domination, enabling the social control of women. For example, some scholars interpreted the existence of reproductive technologies as promoting experimentation on women’s bodies, and their transformation into ‘mother machines’ at the command of men (e.g. Corea, 1985). Due to technology’s association with hegemonic masculinity, all forms of technology, even if not directly applied or controlled by men, were considered tools for the domination of women by some authors (e.g. Mies, 1987; Corea et al., 1987).

In contrast to this position, some scholars problematised the notion that such technologies had inherently negative consequences for women. Instead, liberal feminists argued that technologies themselves could be interpreted as neutral, having the ability to both empower and disempower women. It was the “cultural and political climate in which they are embedded” that must be challenged (Stanworth,

1987: 26). Wajcman disagreed, pointing to the fact that historical and social relations are built into all technologies, thus structuring the choices women are able to make (Wajcman, 1991: 62). This is inescapable due to the fact that forms of knowledge, and its products, are unavoidably 'situated' (Haraway, 1991b). For example, techniques such as IVF may enable those unable to conceive to achieve motherhood, but they simultaneously influence the decisions women make, propounding the value of genetic relatedness and traditional biomedical models of conception, as well as pathologising the inability to conceive (Modell, 1989; Franklin, 1997). Other authors have also pointed to the role of reproductive technologies in constraining women's choices through the 'stratification' of reproduction, for example through inequalities in access according to ethnicity or socioeconomic position (Ginsburg and Rapp, 1995)

Both liberal feminists, and early opponents of reproductive technology have been criticised for essentialising the categories of both gender and technology. Science and technology studies (STS) has since offered theories of technology which have been influential in contemporary feminist understandings of the relationship between gender and technology. The social constructivist theories of the 'social construction of technology' (SCOT), and actor-network theory (ANT) consider both the social and the material as mutually influencing the design and acceptance of new technologies. Indeed, ANT rejects an understanding of the 'social' and the 'technological' as two separate spheres, instead regarding agency and action to be constituted through a 'network' of human and non-human (including technological) actants (Latour, 1987). These approaches offer several concepts that have been found useful by feminist scholars analysing the relationship between technology and gender. A concept from ANT, 'inscription', suggests that in the design phase, the interests, motives and behaviours of future users are anticipated and built in to a technology (Akrich, 1992). Feminist authors, including Wajcman (1991), have used this concept to demonstrate that gendered assumptions are often embedded into the design and development of artefacts. However, these assumptions do not necessarily prevail. The concept of 'interpretive flexibility' (Pinch and Bijker, 1984) points to the fluidity of meanings bestowed upon technologies, and the potential for variation

in users' interpretations of artefacts. Actors therefore have the potential to re-figure the inscribed uses of particular technologies. An example of this would be the use of IVF by single parents, or homosexual couples (Mamo, 2007a).

More recently, the work of scholars such as Haraway (1991a), claims that humans and their bodies have now become so thoroughly fused with technology that the two are no longer impermeable. A 'natural' physiological body does not exist, but is made and remade through science and technology (Wajcman, 2000). This entails positive implications for feminism, having the potential to disrupt conventional family and gender categories (Haraway, 1991a). Existing work has, however, also pointed to how users may interpret the technology in ways that uphold traditional notions of kinship (Thompson, 2001).

Following this introduction to debates surrounding technological intervention in pregnancy more generally, the section below will present a discussion of technologies that are situated in (for some, routine) antenatal practice.

2.2.2.1 Technology and the experience of pregnancy

One of the technologies most routinely engaged with during pregnancy is the ultrasound scan. Ultrasound technology provides an example of the flexibility of the use and meanings of technologies, having been originally designed in the early twentieth century for the detection of submarines and icebergs. Indeed, its movement into the medical realm renders problematic any notion of technologies as emerging linearly from an initial scientific breakthrough (Yoxen, 1987). By the 1950s, ultrasound was being used in the practice of obstetrics (*ibid*). Ultrasound is perhaps the most theorised of technologies used during pregnancy (e.g. Mitchell and Georges, 1998; Taylor, 2008; Roberts, 2012). Some authors have pointed to the potential for ultrasound to limit women's rights and choices in pregnancy. This is linked to its presentation of the foetus as an independent being, against which women's reproductive freedoms can be opposed (Zechmeister, 2001). This situation has also been attributed to the fact that visualisation of the womb allows those other than the pregnant woman herself have access to information about the foetus,

rendering her invisible (Rothman, 1988: 113). Petchesky (1987: 277) argues that a woman's subjectivity is thus no longer important to an assessment of the health of a pregnancy, with her bodily knowledge discredited in favour of privileged, apparently 'objective', visual knowledge.

As touched on above, techniques of observation and visualisation have been an important aspect of the positioning of medical practitioners as experts of the body, and of their professionalisation (Turner, 1987). Medicine has a strong tradition of emphasising the visual as an important means of knowing about the body, exemplified by its culture of dissection in the early modern period (Sawday, 1995), and use of anatomical models. The latter were often heavily gendered, a demonstration of how medical knowledge of the body shapes and is shaped by social life (Jordanova, 1989). Today, the visual culture of medicine is exemplified through the wide use of visualising technologies including Magnetic Resonance Imaging (MRI), X Rays, and of course, ultrasound. Joyce (2005), focusing on MRI, explains that the privileging of visual modes of knowing in medicine as authoritative has been contributed to by the positioning of images as interchangeable with "the thing depicted" (Joyce, 2005: 440). Hence images, including those produced by MRI, are often seen as superior to other modes of knowing. These include physical examination, described by the medical professionals interviewed by Joyce as subjective, and thus unreliable (2005: 444).

However, though often exalted in practice, Haraway (1997) argues that there are no unmediated images, each privileging a certain perspective, with that which is pictured being "rendered in ways that accentuate certain features of interest" (Yoxen, 1987: 282). The viewer too is primed to see "what we have already learned to see" (Treichler et al., 1998: 3). This is also true of the 'God-like' ultrasound screen, which seems to display a disembodied foetus (Haraway, 1997). That this foetus as we know it owes its existence to visualising technologies (*ibid.*: 174), has led some theorists to describe foetuses as 'cyborgs' or 'technofoetuses' (Franklin, 2006). These are "hybrid creatures fabricated out of diverse, highly technical practices" (Casper, 1998:

104), which can also be seen to emerge through other technoscientific activities such as foetal surgery.

Due to the significance ascribed to visualising technologies by both medical professionals and their patients in contemporary culture, and because the processes involved in the production of foetal images are often obscured, some authors have pointed to the potential for ultrasound to erode the “special relationship” women are said to have with foetus (Sandelowski, 1994: 231). For example, an ultrasound scan provides access to the foetus for male partners, and has now become an important ritual in the transition to fatherhood (Draper, 2002). Sandelowski (1994) postulates that whilst women are erased from view through the technology, their bodies absent from the ultrasound screen, men’s experiences of the foetus are enhanced, and have the potential to trivialise women’s embodied knowledge of their pregnancy. This may also be said for enhanced experiences of the foetus for other family members such as grandparents (Harpel and Hertzog, 2010) or female partners.

That the scan can be shared with family members, whilst simultaneously retaining its original purpose of providing clinical information with regards foetal wellbeing, is indicative of the “hybrid” nature of the practice of ultrasound during pregnancy (Taylor, 1998). Taylor (1998: 25) describes how this dual nature of the scan is built into the very architecture of ultrasound technology, which as well as diagnostic functions also features a swivel screen, and a printer enabling women and their partners to take copies of the image away with them (which are also often shared with wider family and friends). The ultrasound scan is emblematic of the heterogeneous processes shaping the experience of pregnancy, and demonstrates the co-production of science, technology, and the social order (Jasanoff, 2004). This is through both the reflection and creation of expectations that women and others derive psychological benefits from the ultrasound scan, including the notion of ‘bonding’ with the foetus (discussed further in Section 2.3.2).

Some authors have asserted that the increasing number of technological interventions, and the democratisation of access to the foetus they allow for, have not

only altered women's embodied experiences of gestation, but also devalued these (Rothman, 1988; Duden, 1992). Duden (1992; 1993) for example, asserts that the experience of 'quickening' - a woman's first bodily experience of foetal movements - has been transformed by the technoscientific practices they engage with during gestation. Where once this experience would have provided the first definite proof of a pregnancy, today technologies such as the heartbeat Doppler or ultrasound scan are said to have rendered quickening obsolete. This once intimate experience has been replaced by technological, and public, knowledge of the pregnancy, asserts Duden (1993: 80). Indeed, in contemporary UK culture the term is rarely used. As such, women no longer need to be asked about the pregnancy, their own, 'haptic' (sensed through touch) experiences devalued in favour of the 'optical' knowledge provided by ultrasound (Duden, 1993). Nonetheless, this assessment may be said to create an artificial juxtaposition of technological and embodied knowledge of the pregnancy, which are in fact difficult to disentangle, and which may both be valued by women (Ross, 2012). Further, contemporary work in this area has also highlighted the potential for ultrasound technology to reinstate women as the subjects of their pregnancies, for example through visualisation of the placenta as interconnecting pregnant women to the foetus (Palmer, 2009). Taking the concept of the technofetus, Casper suggests that attending to the social and technical relations which produce foetal cyborgs helps us to recognise that these are made and transformed *within* women's bodies (Casper, 1995)

The notion that women's embodied experiences are devalued by technological intervention will be further analysed with reference to qualitative data in Chapters Five and Six. These will also draw on additional artefacts and technologies that aim to 'know' the foetus during pregnancy including the ultrasound Doppler, which has thus far been under-theorised. The next section considers another set of technologies experienced by women; those used for the purposes of prenatal diagnosis.

2.2.2.2 Prenatal diagnosis and the 'tentative pregnancy'

Whether or not women's embodied knowledge of pregnancy may be said to be devalued by technological intervention, authors have pointed to other ways in which

such interventions have the potential to shape the experience of pregnancy. For authors such as Rothman (1988), Rapp (1988; 1998; 1999) and Gregg (1995), this is due to the decisions that must be made by women in light of the introduction of prenatal diagnostic and screening technologies to their pregnancy. As Gregg (1995) points out, and as this chapter seeks to demonstrate, the development and use of prenatal diagnostic technologies reflect cultural and social expectations regarding motherhood, women and disability. Amniocentesis is one such technology. The test can detect foetal chromosome abnormalities from a sample of amniotic fluid, following its extraction trans-abdominally (Rapp, 1999: 28). It can detect genetic conditions including Down's syndrome and Tay Sachs disease. Following the procedure, if an anomaly is detected, this may be followed by an abortion (Rapp, 1999; NHS Choices, 2014).

Gregg asserts that the availability of amniocentesis and other prenatal tests may heighten a woman's feelings of responsibility for the pregnancy. This is due to the implications of any decision to reject or undergo testing (for example, the amniocentesis procedure carries a "small" (1 in 100) risk of miscarriage (NHS Choices, 2014)), and choices made in response to the results of such tests (Gregg, 1995: 137). Indeed, Rapp asserts that pregnant women have increasingly become "moral pioneers", placed in a position where they must themselves judge standards for entry into the human community (Rapp, 1998: 165).

For Rothman too, these decisions and their consequences place women in a difficult position. She explains that the very existence of diagnostic technologies such as amniocentesis introduces the possibility that a woman's pregnancy may not result in a baby. However, society simultaneously asks women to protect the health of the foetus, create 'bonds' with the foetus through the ultrasound scan, and prepare for a coming baby. Amniocentesis, used during the second trimester of pregnancy, is particularly significant here, as by this time women may have begun to feel foetal movements. Rothman described that her research participants were placed in a "limbo" whilst waiting for the results of amniocentesis, unsure whether they would become "mothers or carriers of a defective foetus" (1988: 7). According to Rothman,

this “limbo” is also a feature of women’s decisions regarding whether to undergo the test. This period of uncertainty with regards the success of the pregnancy has been termed the “tentative pregnancy” by Rothman:

The new technology of reproduction puts women into a difficult social state, the condition I think of as a “tentative pregnancy”. A woman’s commitment to her pregnancy under the conditions imposed by amniocentesis can only be tentative. She cannot ignore it, but neither can she wholeheartedly embrace it...The pregnancy may not be leading to a baby but to an abortion (1988: 101).

Due to this, it may be necessary for women to maintain an emotional distance from their pregnancy. This may also change their embodied experiences. For example, Rothman argues that amniocentesis changes the meaning of foetal movement. It no longer provides a means of reassurance, which following the procedure comes instead from the test results. Rothman further postulates that women may even delay becoming aware of foetal movement until they have received the results of amniocentesis (1988: 104).

Rothman’s description of the experience of a “limbo” or “suspended animation” whilst undergoing amniocentesis has been invoked often with regards prenatal diagnostic testing. Yet its utility as a concept to describe other aspects of women’s experiences of pregnancy, throughout the nine months of gestation, has been underexplored.

Diagnostic technologies also shape experiences of pregnancy by placing pressures on women (and often their partners) to make a series of decisions with regards the information provided by these interventions. Gregg writes that the existence of such technologies has created a situation where choices *must* be made, to the extent where these choices may be called “forced” (1995: 138). Lippman (1999a) questions whether decisions made by women with regards tests such as amniocentesis can be described as ‘choices’ at all: is one able to choose to continue with a pregnancy following a diagnosis of genetic abnormality, when society does not readily accept children with disabilities, or provide adequate support? Individual choices with

regard the prenatal diagnostic technologies described above are thus constrained by biological processes (and consequently the timing of the test), the situated communication of medical professionals, and societal pressures. The latter is especially pronounced during pregnancy and childbirth, which, for reasons outlined in Section 2.2.3.1, are particularly subject to scrutiny.

Various authors have thus expressed unease at the rapid adoption of prenatal diagnostic technologies, with some of these now incorporated into routine antenatal care. Lippman (1991), highlighting the social and cultural shaping of these technologies, points to a move towards ‘geneticisation’ in contemporary culture, whereby differences between individuals become understood as rooted in their DNA (1991: 19). She argues that the ever-expanding set of populations to which prenatal diagnostic technologies are applied, and increasing number of conditions they detect (defined by medical professionals), demonstrates their powerful role in this process (*ibid*).

Ettorre (2000) describes that an emphasis on genetics in medical discourse rests on a view of the body as a machine, with a notion that ‘bad genes’ can be somehow replaced or removed (2000: 406). In line with this, Rothman (2000) highlights the language of medicine in the age of genetic testing, whereby foetuses are described as ‘products of conception’ (2000: 5). In a society encouraging prenatal testing, genetic counselling and screening serve the function of “quality control on the assembly line of products of conception, separating out those products we wish to develop from those we wish to discontinue” (2000: 6). Through these technologies, it has been argued that a cultural message to have ‘perfect’ children is promoted to women (and their families) experiencing pregnancy, which Ettorre argues is promoted strategically by the medical profession “to engage them in a disabilist discourse” (2000: 412). Various authors have thus expressed disquiet at the discrimination they see as inherent in prenatal diagnostic technologies (Gillam, 1999), articulating that focus should instead be on society’s discriminatory practices (Lippman, 1991: 45), and also at the potential for selective abortions relating to wider characteristics, including foetal sex (Rothman, 2001: 198).

However, these aspects of prenatal diagnostic technologies are often downplayed, with such technologies instead presented in terms of the ‘benefits’ they offer to women: including autonomy in decisions regarding the children they will bear, and also their ability to ‘reassure’ women, thus enhancing their experiences of pregnancy (Lippman, 1991: 22). This goes some way to explaining their widespread routinisation. Press and Browner (1997), for example, demonstrate that women’s acceptance of the maternal serum alpha fetoprotein (MSAFP) test for neural tube defects has been accomplished through its positioning, conceptually and procedurally, under the rubric of routine prenatal care (1997: 984). The women in their study saw the acceptance of prenatal care, and thus prenatal testing (with MSAFP described as ‘a simple blood test’), as a maternal responsibility. The majority had not considered the potential consequences of an unwelcome result, with many not describing the ethical issues to which they may have to attend, instead welcoming the provision of information as a result of the test (1997: 988). The positioning of such technologies as innocuous is soon likely to be re-ignited in a UK context, with the possible introduction of non-invasive prenatal diagnosis (NIPD) into routine care during pregnancy. In preliminary views exploring public reaction to this prospect, however, participants exemplified *both* understandings of these tests as providing reassurance and ‘choice’, but also their potential to contribute to social discrimination against the disabled (Kelly and Farrimond, 2012).

The ready acceptance of these technologies may also have been made possible by the lack of discussion surrounding the potential dangers of prenatal screening and diagnostic technologies. Though the risks of miscarriage associated with amniocentesis and chronic villus sampling are communicated to women (NHS Health Scotland, 2014), the safety of ultrasound, used routinely in pregnancies in the UK, has not been unanimously confirmed (Marinac-Dabic et al., 2002; Abramowicz, 2014). Instead, with potential adverse effects obscured, these technologies are promoted as an instrument of ‘reassurance’, and demonstrative of maternal responsibility during pregnancy, through discourses of foetal abnormality and ‘high risk’ pregnancies. That prenatal diagnostic technologies offer the ‘solutions’ to dilemmas created by a language of geneticisation, may thus be seen as allowing for

medicine's continued dominance in the possession of 'legitimate' knowledge of women's pregnancies (Rothman, 1988).

However, though decisions may be experienced as constrained, a number of women do refuse diagnostic tests, and draw on many reasons for doing so (as do acceptors of the test). With regards amniocentesis these can include their religious convictions, levels of education, limitations of the technology in terms the conditions it is able to test for, and the experiences of family and friends (Rapp, 1998). The latter consideration, however, has also been shown to have the potential to further constrain reproductive decisions. For example a family member's (positive) experience with the condition may cause additional hesitation over whether to be tested (Boardman, 2014). Though a decision not to undergo testing may conflict with the recommendations of health professionals, this does not necessarily signal a rejection of the science and technology behind the test. Those who refuse prenatal tests have been shown to draw on the same biomedical discourses underlying the rationale for its acceptance. This has been demonstrated by Markens et al. (1999), who found that women refusing MSAFP drew on similar notions of risk to health professionals, but that these related to the risk of a false positive, or the risk of a miscarriage following the procedure, which were more significant for them than the risk of a positive diagnosis.

Decision making processes with regards prenatal diagnostic and screening tests thus draw on a multitude of sources. They have also been said to depend on which forms of knowledge women understand to be authoritative (Davis-Floyd and Sargent, 1997). Though this concept has since been complicated (see below), the notion of authoritative knowledge has been influential in the field of anthropological and sociological discussions of pregnancy in the wake of its medicalisation. Developed following a comparative study of birth in four cultures (Jordan, 1978), Jordan defines 'authoritative knowledge' as forms of knowledge which come to "carry more weight than others, either because they explain the world better for the purposes at hand, or because they are associated with a stronger power base, and usually both" (Jordan, 1997: 56). In European and North American settings for pregnancy and childbirth, it

is often biomedical and technological knowledge(s) that are described as carrying most weight, for health professionals but also for women themselves. Their ready acceptance of these forms of knowledge is not conceived of as forced upon women, but achieved by consensus. For example Lazurus' (1997) study of choice and control in birth, among women she describes as 'middle-class' and 'poor', found that those representing poorer socioeconomic groups subscribed fully to biomedical authority with regards childbirth, privileging continuity of care over wanting to have 'control' over birth. This was a preserve of her middle class respondents, who interacted more critically with biomedicine. We see then that knowledge(s) deemed authoritative may depend on sociocultural and experiential context. Browner and Press (1996) comment that during pregnancy the women in their research engaged more critically with biomedical recommendations, which they interpreted, and sometimes rejected on the basis of their embodied experiences of pregnancy (see also Abel and Browner, 1998). Conversely, during birth many acceded to a 'biomedical imperative' and the technologies it entailed (Browner and Press, 1996).

Early discussions of this kind, which draw on distinct notions of biomedical (or 'expert') knowledge, and pregnant women's (or 'lay') knowledge, often conceptualised these as competing (e.g. Graham and Oakley, 1981). This understanding however, has since been nuanced, as have similar discussions in wider sociology. A focus on the knowledge drawn on by women during pregnancy has been important in exposing the influences of women's social context on their experience, and on their engagement with biomedical interventions and advice, demonstrated above. Within the sociology of health and illness, such discussions have been complicated by demonstrations of the entwinement of biomedical and lay discourses in patients' individual accounts and understandings of their experiences (Shaw, 2002; McClean and Shaw, 2005), and also by the notion that many forms of 'expert' knowledge exist, some of which can be held by patients (Collins and Evans, 2002). Further, in the sphere of prenatal testing, authors have suggested that women may come to *embody* biomedical knowledge. Markens et al. (2010) explain this with the example that for foetal movements to provide reassurance, women must first know that this is a sign of a healthy pregnancy: information about which is derived

from medical discourses. This highlights that relationships between knowledge sources are dynamic, complex and synergistic (Markens et al., 2010: 52).

This section has demonstrated that biomedical interventions experienced during pregnancy provide an obvious site where women may experience pressures to accord with the advice of health professionals and notions of acceptable behaviour during pregnancy. Their choices may therefore be described as constrained. Another body of work has pointed to further sites, outside a strictly medical setting, through which women may experience regulation or control during pregnancy. These may be much more subtle, and as such, many authors have related them to Foucauldian notions of surveillance and governance.

2.2.3 Risk, uncertainty and pregnancy

In the brief discussion of medicalisation above, medical institutions were introduced as sites of social control. The writings of French philosopher Michel Foucault have been extremely influential in contemporary understandings of how the medical domain came to acquire and maintain such a position. I will not dwell on Foucault's influence here, or expand on the application of his theories to pregnancy, due to the large body of such literature already in existence (e.g. Sawicki, 1991; Weir, 2006; Shaw, 2012; see Petersen and Bunton, 1997 for the influence of Foucault on medical sociology more generally). However, it is important for what follows to draw attention to his understanding of power as dispersed and enacted in everyday practices. Power was conceptualised by Foucault as working at the level of individual bodies, rendering them 'docile' through techniques of surveillance, and thus the encouragement of self-discipline (see Foucault, 1979; Armstrong, 1995). For some authors, this understanding of the relationship between social institutions such as medicine, and their operation at the level of individual bodies, corresponds with sociocultural theories of modernity. Again, many volumes explore these debates (e.g. Lupton, 1999a; Beck et al., 2000; Zinn, 2008), and as such I shall not go into too great a depth in this review. I instead present a brief overview in what follows of how these discussions have been drawn on in contemporary scholarship relating to pregnancy.

Along with Foucauldian understandings of power and governance, Beck's theory of the 'risk society' (1992), and Giddens' (1991) work on late modernity are often drawn on in social science literature regarding pregnancy. These authors see the late modern era (defined late twentieth century, post-industrial society (Beck, 1992: 10)) as characterised by the proliferation of risk. For Beck, this is due to the fact that processes of modernisation, including technological and economic development, have produced previously unknown hazards. The notion of risk is invoked as a means of dealing with these new threats, through quantification and attempts at its management (1992: 20-21). For individuals, late modernity thus involves a large amount of preoccupation with and monitoring of risk (Giddens, 1991: 115). Today's risks are seen by Beck (1992) as qualitatively different to those experienced in past eras. These are often invisible and at times unknowable. Uncertainty is therefore a key element of the risk society, and individuals may be critical of institutional, such as scientific, knowledge, due to its inability to resolve this uncertainty. They therefore must make decisions regarding risk for themselves, drawing on their own biographies (Beck 1992: 135). The risk society is characterised, then, by personal and social introspection, and as such both Giddens and Beck invoke the concept of reflexivity in their descriptions of modernity.

The risk society thesis has been critiqued for being too 'grand' a theory (Dingwall, 1999). Indeed, pre-existing literature had already pointed to the importance of cultural context in conceptualising individuals' understandings of and responses to risk (Douglas, 1986). Despite this criticism, and recent warnings that there has been an over-extension of risk theorising in the field (Green, 2009), the notion of the 'risk society' has been, and remains, influential in the sociology of health and illness. The late modern medical emphasis on health risks, and their prevention through strategies of health promotion at the level of the individual, have been particularly amenable to analysis in terms of 'risk society' theories, as well as Foucauldian theories of governmentality, outlined above (e.g. Castel, 1991; Petersen and Lupton, 1996).

These two theoretical approaches have often been taken in the discussion of the medical management of pregnancy (Lupton, 1999b; Ruhl, 1999; Weir, 1996). During pregnancy women are portrayed as particularly susceptible to risk (Lupton, 1999: 63). For example, prenatal care is administered according to whether women are categorised as 'high risk' or 'low risk' (this can be due to their age, or according to the presence of conditions such as diabetes or obesity), and as we have seen, women are subject to many forms of monitoring including through midwife appointments and prenatal screening technologies. Indeed, in line with Beck, Jones (2007) suggests that for recipients of screening and diagnostic tests, it is only through entering into discourses of risk by agreeing to antenatal screening, that risks to pregnancy become apparent.

Because risk has been established as a significant feature of the contemporary experience of pregnancy, it is important that I attend to a related concept: that of uncertainty. The concept of uncertainty has long been engaged with by STS theorists. This has been in terms of how uncertainty is managed in scientific practice. Star (1989), for example, describes the threat posed by uncertainty (in the form of anomalies or ambiguities in scientific research) to its mandate to produce generalisable, universal results. Uncertainty is thus something to be worked upon. Local manifestations of knowledge may be transformed into global certainty thorough the use of, for example, standardised models substituted for data containing irregular findings, or through the substitution of ('certain') clinical evidence from other fields. Kerr (2000) describes such techniques in her discussion of genetic research. In her exploration of the scientific search for a continuum between two genetic conditions, she outlines how uncertainties may be annulled, ignored or re-framed in scientific practice. In the case of Cystic Fibrosis and male infertility, these practices suppressed the messy processes of defining diseases and genes, thus contributing to genetic reductionism. However, in contrast, Moreira et al. (2009) have discussed how practitioners may *mobilise* uncertainty in order to re-open black-boxes within biomedical knowledge, thus providing spaces to reformulate diagnostic categories, rules or conventions. In scientific practice then, uncertainty may be

worked upon in order to effect its elimination *or* production, in both cases serving to innovate new knowledge.

The explicit consideration of uncertainty has recently become more common in sociological literature regarding risk (e.g. Zinn, 2008). In this context, Lyng (2008: 110) explains that where the concept of ‘risk’ entails a specific range of outcomes, and thus implies an amount of determinacy, ‘uncertainty’ refers to that which is unknown, and indeterminate. Much useful discussion of the concept in these terms has come from the sociology of health and illness. This often relates to how patients *manage* the uncertainty stemming from being assigned an ‘at risk’ status. For some, this is achieved by attempting to assert control over their illness or other aspects of their lives (Weitz, 1989; Keeley et al., 2009). Scott et al (2005) found that following the assignment of an ‘at risk’ label for genetic cancer, participants described a state of ‘liminality’. In response to this, participants sought medical intervention to constantly monitor their state of health. Due to the contribution this made to resolving uncertainty, some interviewees categorised as ‘low risk’ strove to re-position themselves in higher risk categories, in order to access similar levels of surveillance (Scott et al., 2005: 1878). In connection to this, and echoing Beck, Sulik’s (2009) work with those diagnosed with breast cancer concluded that advances in science and medicine heighten biomedical uncertainty, whilst simultaneously increasing patients’ reliance upon them. Patients must ultimately, however, accommodate risk and uncertainty for themselves. This accommodation is discussed in a recent study in the field of pregnancy. Here, women drew on complementary and alternative medicine in order to manage the uncertainties of pregnancy outcomes. Alternative therapies were seen to offer security and a means of influencing the future, insufficiently addressed through maternity care alone (Mitchell and McClean, 2014).

Following these examples, in contrast to Lyng’s (2008: 110) definition, above, it seems that uncertainty as understood by these individuals refers to how they experience the (at times quantified) risks presented to them in their engagement with the medical profession. Rather than a being state of ‘indeterminacy’, for the

participants above the potential outcomes *were* knowable. It is the liminality resulting from ‘not knowing’ which of these will occur, that more appropriately fits with the notion of uncertainty they describe. Indeed this conceptualisation of uncertainty resonates with Rothman’s (1988) notion of the tentative pregnancy, described above. Here, women described being placed “in limbo” or “suspended animation” (1988: 100-103) whilst they waited for amniocentesis results, uncertain as to whether their pregnancy would end in a baby, or an abortion.

It is thus important to pay attention to how individuals manage not only the experience of risk, but also the uncertainty that may result from being positioned as ‘at risk’. Due to the conceptualisation of pregnancy in health services in terms of risk, uncertainty is likely to be a notable element of women’s experiences. Attention to facets of risk such as uncertainty may also prove fruitful in a move away from discussion of pregnancy solely in terms of sociocultural theories of risk, such as the ‘risk society’ thesis. These types of discussion have recently been critiqued for “limiting analytical horizons” (Coxon, 2014: 485). How this thesis contributes to this project is discussed further in Chapters Seven and Eight.

2.2.3.1 ‘Advice’ and surveillance

During pregnancy, in line with the discussions of self-governance and modernity described above, authors have highlighted that in the contemporary era emphasis is placed upon women themselves to manage many of the ‘day-to-day’ risks seen to threaten pregnancy (Lyerly et al., 2009). This is reflected in the plethora of advice received by women at this time, relating to physical activity (Nash, 2011b), diet (Copelton, 2007), and substances such as alcohol (Armstrong, 2003) and tobacco (Oaks, 2001). Yet for some of these substances, notably alcohol, there is uncertainty with regards their potential for harm, both amongst pregnant women but also health professionals. In the face of this uncertainty, abstinence from alcohol is advocated by UK policy, and in other countries, in what has been termed the ‘precautionary principle’ (Leppo et al., 2014). This has drawn criticism from scholars who see this as further constraining women’s choices (e.g. Lowe and Lee, 2010; Gavaghan, 2009).

The advice outlined above is received by women directly from health professionals, but also in the form of pregnancy handbooks. These have been said to maintain the repertoire of ‘pregnancy as risk’, and contribute to the (subtle) regulation of women’s behaviour (Marshall, 2000). Emphases on self-regulation and self-surveillance during pregnancy, which includes the requirement to undergo recommended prenatal tests, is intensified due to the presence of a foetus, often conceptualised as separate from the pregnant body, and sometimes as an individual in its own right (see Section 2.3).

Scholars have argued that the conceptualisation of the foetus as already a person has allowed for the extension of parenting ‘backwards’ into the prenatal period (Keenan and Stapleton, 2010). Women’s behaviour during pregnancy has been rendered a moral issue, judged as to whether it conforms to dominant understandings of ‘good motherhood’ (Bell et al., 2009). Women’s actions during pregnancy are thus particularly subject to scrutiny, and not only from those offering antenatal care. Authors have documented incidents of women receiving comments and advice regarding pregnancy from friends, family and even strangers (Fox et al., 2009; Longhurst, 1999). This has not been only due to concern for the wellbeing of the now ‘public foetus’, seen in comments made by strangers regarding women’s consumption of certain foods or alcohol, but also with regards women’s body image at this time. Similar comments may also come from health professionals (Nash, 2012b). Importantly, like their engagement with prenatal diagnostic technologies, women have been shown to approach antenatal advice flexibly, influenced by their own understandings of what will enhance foetal well-being (which may conflict with biomedical recommendations), but also by the constraints of their daily lives (Markens et al., 1997; Hammer and Sophie, 2014).

2.2.4 Summary

This section has outlined shifts in understanding and the management of pregnancy from community based (female) attendants, with expertise based on experience, to trained professionals within the medical domain. Late twentieth century feminist debates conceptualised this as contributing to the domination of women’s bodies by

the (largely male) medical profession. This was seen to be diffused through the technologies and regimes of care often readily engaged with by women, who were thus complicit in cementing medical knowledge of pregnancy (as opposed to their own) as authoritative. Authors have also described how its medical management has entailed changes to women's experiences of pregnancy and their bodies. Of particular interest to this thesis is the notion that women may engage with their pregnancy 'tentatively', in the face of discourses communicating that a successful pregnancy is not guaranteed. Though the concept of the 'tentative pregnancy' has often been invoked in discussions of prenatal diagnostic technologies, it is rarely engaged with elsewhere.

The notion that the pregnant body is 'at risk' has been a common theme in contemporary social science literature. Such work often draws on Foucault's conception of disciplinary power, working at the level of individual bodies and encouraging self-governance, but also sociocultural theories of modernity, whereby risk is advanced as a defining feature of the late modern period. Antenatal care has been presented as a means of regulating pregnant bodies with reference to risk, as have the various resources available to women at this time, but also their wider social networks. Recent work, however, has argued that academic adherence to sociocultural theories of risk may be limiting the scope of social science research regarding pregnancy (Coxon, 2014).

The next section will discuss an important component of women's experiences of pregnancy, the foetus, which is today variously been termed the 'public foetus' or 'foetal subject' in social science literature. Many commentators see the contemporary accessibility of the foetus as a key factor contributing to the construction of pregnancy as risky, and in need of management.

2.3 Pregnancy and the foetus

The foetus as it is known by many in Britain today did not always exist, being the product of a particular historical and socio-cultural context (Duden, 1999). Within the last thirty years, feminist scholars have participated in debates regarding the

presence of the foetus in narratives of human development, anti-abortion discourse, and the pregnancy accounts of individual women. This follows the unwillingness of some to engage with the foetus, lest this legitimated pro-life campaigners' vision of a 'foetal subject' (Layne, 2003). Recognition of the need to work "through" the foetus, rather than "around" it (Morgan and Michaels, 1999: 2), has since resulted in important contributions to understandings of women's experiences of pregnancy, and the politics of reproduction.

2.3.1 Creating the foetus

Perhaps the most widely addressed issue in feminist engagements with the foetus is the potential for an understanding of the foetus as an autonomous 'person'. Though the foetus has historically been portrayed in anatomical drawings as a fully formed 'person' in the womb (Newman, 1996), feminist discussions of this phenomenon have centred on the introduction of medical technologies to pregnancy management. The ultrasound scan in particular features in many of these debates. Working in the era of the routinisation of imaging technologies, Rothman asserted that these "new images of the foetus and even embryo are making us aware of the "unborn" as people" (Rothman, 1988: 114). Like others, she argues that the foetus has become a metaphor for a 'space man', floating free and seen as an independent human being, able to fend for himself (Petchesky, 1987). In connection with this, theorists have focused on how the rise of the foetus within public consciousness has also been allowed for by emergent techniques of foetal photography in the 1980s, and the presence of such images in media such as films (Stabile, 1992). Many argue, as discussed above, that as a result of these representations of the foetus as a - perhaps *the* - subject of pregnancy, women's bodies have become absent or peripheral (Petchesky, 1987; Duden, 1993).

More recent developments in medical technology have also contributed to the foetus becoming a *patient* in its own right, further enabling a biomedical understanding of the foetus as person. Foetal surgery, developed in the late twentieth century, enabled the foetus to be considered intimately 'knowable' and treatable, and entailed a branch of medicine dedicated to the foetus: foetal physiology (Casper, 1998: 76).

These medical developments also provoked consideration of foetal viability: the capability of the foetus to survive outside the womb, serving to further emphasise foetal autonomy. Technological interventions rendering the foetus autonomous, theorists argue, have made possible a notion of maternal-foetal conflict. This is highlighted in medical metaphors of the foetus as an immunological intruder (Martin, 1998). Many have claimed that this has been an important contributor to the increase in medical and legal management of pregnant women, such as forced caesarean sections, to ‘protect’ the foetus in cases where a woman refuses or is unable to consent (Petchesky, 1987; Daniels, 1993).

However, it is important to note that pregnant women are not passive recipients of these technological transformations of the foetus, and in many cases have been shown to welcome the portrayal of the foetus as a ‘person’. Numerous qualitative studies have been carried out with women experiencing ultrasound scans. Though some recognise the dilemmas of choice and anxieties associated with prenatal diagnostic testing and screening, discussed above (e.g. Harris et al., 2004; Mitchell, 2004; Gammeltoft, 2014), many authors describe the enthusiastic accounts of women engaging with ultrasound. Mitchell (2001), for instance, documents the positive experiences of women in Canada, who felt that the scan provided ‘proof’ of the reality of pregnancy, but also contributed to the construction of a foetal identity (signalled by the title of her book: *Baby’s First Picture*). Taylor’s work (1998; 2008) points to the ultrasound as an important site for prenatal ‘bonding’ (first postulated in Fletcher and Evans, 1983), describing that “ultrasound technology accelerates and improves upon the natural process by which pregnant women enter into a specifically maternal relationship with the foetus” (2008: 77). In accordance with the notion of ultrasound bonding, private clinics now offer specific ‘bonding scans’ to women, which are often in 3/4D to offer clearer and more powerful images of the foetus to women (Roberts, 2012). As highlighted in Section 2.2.2.1, above, ultrasound has been said to have equalised access to the foetus, providing the opportunity not only for women to bond, but also their partners present at the scan, and wider family members with the sharing of ultrasound images or videos (Taylor, 1998; Han, 2009b). The notion of prenatal bonding has been a powerful discourse in both

popular and scholarly discussions of women's experiences of the ultrasound scan, and pregnancy more generally. Nevertheless, the existence of an innate bond between a pregnant woman and her foetus is open to question.

2.3.2 The concept of prenatal bonding

The emotional connection between a mother and her infant has been frequently addressed by psychological literature within the last fifty years. Bowlby's attachment theory ([1969] 1982), developed from research in ethology, psychology and evolutionary biology, proposed that the 'attachment instincts' observed between a mother and her young child were essential to a species' survival. Processes of attachment were later discussed in relation to the moments after birth, with the notion of bonding used to explain the observation that mothers who spent sixteen hours additional contact with their babies after birth "engaged in significantly more eye-to-eye contact and fondling" (Klaus et al., 1972).

The concept of maternal-*foetal* bonding did not appear until later in the 1970s, when scholars such as Rubin (1976) and Cranley (1981), hypothesised that women undertake specific emotional tasks during pregnancy, including interacting with their unborn child, in preparation for motherhood. The latter developed the concept of 'maternal-foetal attachment', a term now used to describe the maternal-foetal relationship in many medical and psychological studies. The concept of bonding with the baby during pregnancy is today familiar to pregnant women in the UK, and to those who provide antenatal care. For example, bonding is encouraged in the literature provided to pregnant women by the NHS (in England and Wales), which describes ways to 'bond with your bump' (Department of Health, 2009: 23).

Some authors, including feminist commentators, have discussed the maternal-foetal relationship in terms of a natural connection. In her discussion of obstetric technologies, Oakley explains that "mothers and fetuses were in a relationship with one another before they met on the ultrasound screen" (Oakley, 1993: 196. See also Rothman, 1988: 115). Qualitative studies with women experiencing pregnancy seem to support this, suggesting that women may expect and desire to bond with their

'baby' at this time. In many cases women make efforts to feel such a connection with the foetus, including through the purchase of blue or pink baby clothes (Taylor, 2008: 122), and the naming of the baby during pregnancy (Mitchell, 2001: 159). Many studies have reported that women consider the ultrasound scan to be an important and enjoyable aspect of bonding (Taylor, 1998; Mitchell, 2001; Roberts, 2011). However, though the expectation that maternal-foetal bonding occurs during this procedure has been problematised (Petchesky, 1987), for fear that it reasserts the association of motherhood with womanhood, it must be considered that this discourse can also entail expectations of male partners to perform fatherhood during the scan (Ivry and Teman, 2008), and that opportunities are provided to extended family such as grandparents (Harpel and Hertzog, 2010), to bond with the foetus. This has the potential to shift expectations of prenatal bonding to other family members, again demonstrating the potential of technologies to disrupt traditional conceptions of family and gender (Haraway, 1991).

Despite the acceptance of the notion of prenatal bonding by pregnant women and medical professionals alike, scholars have highlighted the potential of the concept to cause feelings of guilt or failure in women for whom it is not experienced (Eyer, 1992). Various authors have therefore challenged the very notion of a universal and innate bond between a mother and her child, by demonstrating the cultural ideals underlying the concept of mother-infant bonding. These include the understanding of motherhood as analogous to womanhood (Eyer, 1992). Challenges to the concept of an innate mother-infant bond have been supported by empirical research highlighting its cultural specificity. Scheper-Hughes' (1992) ethnographic study amongst the women of a shantytown in Northeast Brazil explored the maternal experiences of these women, who were faced daily with infant death (with an infant mortality rate in the area of 30-40%). Babies born weak or sickly were often gradually and mortally rejected, with a belief that they were ill-fated for life or better off dead (1992: 342). Maternal love, if it occurred, unfolded over time, and only to infants who were likely to survive. The maternal bond has therefore been shown to be shaped by political and economic context, as well as by cultural norms (Scheper-Hughes, 1992).

Despite the contested nature of the concept, we have seen that the existence of a prenatal bond is readily described by existing literature in both the social sciences, but also in clinical arenas. Using quantitative ‘scales’, psychological studies have linked what they term “maternal-foetal attachment” to factors including the postnatal mother-child relationship (Siddiqui and Hagglof, 2000) and prenatal health behaviours (Lindgren, 2001; Sedgmen et al., 2006). This notion of an attachment or bond to the foetus rests on the assumption that the foetus is experienced by women as a distinct and knowable entity, the concept of which will be troubled below, and in Chapters Five and Six of this thesis. While it may be problematised, in line with Petchesky (1987: 75), I acknowledge that to understand the concept of ‘bonding’ as a historically and culturally shaped process is not to deny it exists. As we shall see, women do develop powerful feelings towards the foetus, however it is understood, during pregnancy.

2.3.3 *The patchwork foetus: beyond technology*

We have observed that the dominant understanding of the foetus as a ‘person’ in Euro-American culture has been explained with reference to imaging technologies (and their dominance), which are a common feature of pregnancy today. Indeed, Morgan describes that technologically-generated imagery of the foetus overwhelms all other ways of knowing and imagining foetal bodies (Morgan, 2011). Scholars have also turned attention to the role of material culture and consumption in the construction of the ‘foetus as person’. Layne (2003: 104) critiques anthropologists for their narrow focus on the medicalisation of pregnancy as a lens through which to understand women’s experiences of gestation, which she argues contributes to the dominance of a medical model. Layne considers the role of consumer goods in the construction of foetal personhood: for example through purchase of goods for the baby prior to birth, or gifts given *from* the ‘unborn child’. She also points to the giving and preserving of gifts following a miscarriage or stillbirth, which constructs ‘would-have-been babies’ as real babies, and women as real mothers (Layne, 2003). Related to this, Taylor (2000) asserts that pregnancy is today experienced as a matter of consumption, with women seeking out baby clothes, toys and nursery equipment (see also Han, 2013) and also purchasing diagnostic tests such as the ultrasound scan.

These processes construct the foetus as person *and* commodity simultaneously (Taylor, 2000).

As demonstrated through the role played by consumption, for women and their families, the conceptualisation of the foetus as already a 'person' has not only been allowed for by its visualisation through ultrasound. Han (2013: 87), who conducted interviews and observations with American women, points to how the ultrasound scan also provides women with the opportunity to "bond" through talk, for example by waving to the "baby" on the monitor and saying 'hello'. Outwith the context of the scan, women may also communicate with the foetus through what Han describes as "belly talk". She sees this as represented by women patting or massaging their pregnant bumps, greeting the bump, or through the reading of stories. Han sees this as making the unseen baby in the belly "real and present" to the pregnant woman (2013: 69), and thus represents an important part of the "language socialisation of women as mothers" (2013: 61). Again, as described above, Han's equation of pregnancy with being a mother, or as a type of 'pre-motherhood', is problematic.

Communication as contributing to foetal personhood has also been described in other work. Ivry (2010) describes the experience of prenatal bonding in Japan, whereby the practice of 'nurturant' behaviours including daily communication with the foetus, eating well and monitoring foetal development through diaries, all contribute to the consideration of the foetus as a baby, and the formation of a bond. Ivry contrasts this with Israeli women for whom pregnancy is understood as a "high risk gamble" (2010: 49), and who are hesitant to bond with their foetuses (echoing Rothman, 1988). These descriptions of pregnancy are useful in highlighting cultural differences with regards the management of pregnancy. However, as we have observed, it is perhaps too simplistic to infer that what these participants describe as bonding is a distinct experience, which can be discussed in terms of its presence (for Japanese women) or absence (due to Israeli women's hesitancy to do so). The accounts given by women in existing research, presented in this brief overview, describe very personal and variable experiences, which would be difficult to label definitively as signalling the presence or absence of 'a' prenatal 'bond'.

One element of these varying experiences may be gestational time. Whilst theorists have generally addressed the identification of the foetus as person or patient from the second trimester onwards (as chiefly constructed through visualising technologies), fewer empirical studies have explored the experiences and understandings of the foetus during earlier stages of development, before the application of medical technologies. Such research could offer new perspectives on women's understandings of the foetus during pregnancy. For example, Layne's (2003) discussions with IVF patients revealed that for some, visualisation of IVF procedures entailed the attribution of personhood to embryos prior to implantation, and even to ripening ovarian follicles (Layne, 2003: 89). This implies that although scholars have described the ultrasound scan as being a major contributor to the conception of the foetus as person, due to its images of a seemingly independent being with distinct human features, the attribution of personhood to the foetus is more complex than just visualising a 'baby'.

2.3.4 *The elusive foetus*

Though this overview has so far presented research portraying, or critiquing the portrayal, of the foetus as a definite entity to which women may be 'bonded', discussions of the foetus outwith the context of a successful pregnancy have pointed to the contingent nature of the foetus. For example, though Casper (1998) describes the processes contributing to an understanding of the foetus as patient through foetal surgery, she has also documented the different positionings of the foetus entailed in the practices of foetal tissue research. Here, the foetus is defined as both a "technology and a tool", with its tissue having unique properties such as the capability of being preserved and then reanimated (Casper, 1994: 314). It has therefore been used in the development of biomedical therapies for conditions including diabetes. Casper sees this positioning of foetal material as part of a project amongst American scientists to draw attention away from the humanity of foetal tissue. Casper describes that the foetus may be simultaneously positioned as a "patient, person and agent", and as a "tool, technology and biomedical therapy" (1994: 317). Similar findings have also been explored amongst the health

practitioners at a single UK hospital, who variously held perceptions of the foetus as a 'person', 'patient' and 'commodity' (Williams et al., 2001). These multiple considerations are further complicated when we consider the foetal entity during the embryonic stage. In the case of IVF, decisions are made by patients with regards which of their embryos will be designated as 'spare', which to donate to research into fertility treatment, and which could be donated to stem cell research (Parry, 2006).

In efforts to further demonstrate its contingent nature, feminist scholars have discussed the cultural specificity of the foetus as experienced by women whose pregnancies are biomedically managed. For example, Conklin and Morgan (1996) explain that the individualistic emphasis on personhood in Euro-American societies is absent in native Amazonian conceptions of personhood. Amazonian societies instead see the human body as a social creation, and a child's personhood as acquired gradually through interactions with other people and the sharing of bodily substances such as breastmilk (Conklin and Morgan, 1996). Similarly, Tsing (2007) describes foetal development as understood by the Indonesian Meratus. Here the foetus is not considered to be innocent and vulnerable; an image projected by biomedical discourse (Oaks, 2001; Lupton, 2012) and harnessed by anti-abortion campaigns. Amongst the Meratus the foetus is understood to find its own "future livelihood, luck, health and wisdom" during the nine months of pregnancy, which will then be lived out after birth (Tsing, 2007: 233). This foetus is wise and determines its own birth and death, and is not seen to be vulnerable and in need of protection. Such variation in conceptualisations of the foetus has also been demonstrated through anthropological comparative studies of miscarriage and stillbirth (Cecil, 1996).

Exploring the changing and culturally variable notions of foetuses as people helps us to understand that the existence of foetus as we understand it today is possible "only at a certain time, in a certain place, in a certain social setting" (Hacking, 2007: 159). Nevertheless, even in the context of European and North American settings, women's accounts may be ambiguous. This has been demonstrated in the case of unwanted pregnancy and abortion (Kimport, 2012). Lupton's research with women

experiencing a wanted pregnancy also describes ambiguous experiences of pregnancy, including being unable to articulate what was happening within them, and moving between conceptualising the foetus as autonomous, but at other times as part of their bodies (Schmied and Lupton, 2001; Lupton, 2013b). This indicates a potential discord between scholarly discussions of the foetus, and the foetus as experienced by some women themselves. Though many theoretical descriptions see the foetus as having been cemented as a distinct and autonomous entity, against which women's reproductive freedoms can be opposed - and to which some feminist discussions of the "foetus as person" may contribute (Morgan, 2011: 333) - this may not correlate with women's own experiences of the foetal entity.

2.3.5 Summary

This section has outlined the emergence of the foetal subject and its diffusion into contemporary (European and North American) public consciousness. As we have seen, many scholars have attributed this to the accessibility of the foetus through visualising technologies. More recent discussions have also pointed to the role of additional practices such as the use of antenatal diaries, purchasing items for the coming baby, and engaging in 'belly talk' (Han, 2013), as increasing women's awareness of the foetus, and potentially contributing to its personification.

It has also been shown that the existence of 'a' foetus, to which personhood can be assigned and women (and their families) can be bonded, is historically and culturally contingent. As we have observed, personhood may be postponed until long after birth in some regions. Conversely, personhood may also be assigned to a foetus that is not yet present, observed in Layne's (2003) example of ripening ovarian follicles for IVF patients. Even in well established, biomedically managed pregnancies, women have voiced uncertainty with regards the entity within, but also fluidity with regards their understandings of the foetal entity over the course of pregnancy. Yet, little qualitative research considers these experiences over time, with the majority focusing on women's conceptualisations of the foetus during or following specific interventions, such as the ultrasound scan.

Before we can talk of a foetus, and of bonding, it is important first to understand how individual women conceptualise the entity within them, and linked to this, how they relate to their pregnancy. Rothman indicates that this may be influenced by understandings of the pregnancy as ‘tentative’. The next section of this review considers an aspect of gestation familiar to all those experiencing it, regardless of their approach to pregnancy – the inevitable changes to the body it entails.

2.4 ‘Doing’ pregnancy – embodiment and experience

Being an inherently physical experience, encompassing distinctive and at times dramatic changes to women’s bodies, pregnancy represents a unique case through which to examine academic debates regarding the body. In what follows, sociological and anthropological discussions of the body and embodiment are outlined. Discussions of pregnant embodiment specifically are then addressed, along with the implications of these for social scientific approaches to the body.

2.4.1 Transcending dualisms

Many texts focusing on the body highlight its absence in social science literature until the late twentieth century. This is largely attributed to the historical conceptualisation of the mind and body as distinct, and the privileging the former in social theory (Shilling, 2003), but also to the bracketing of the (notion of a) bounded, physical body into the domain of the natural sciences (Farquhar and Lock, 2007). Since the 1980s, scholarly engagement with the body has increased dramatically. This is evidenced with the publication of numerous monographs (e.g. Turner, 1984; 1992; Leder, 1990; Shilling, 2003) and edited collections (Featherstone et al., 1991; Watson and Cunningham-Burley, 2001; Fraser and Greco, 2005) with ‘the body’ or ‘bodies’ as their focus, and the launch in 1995 of an academic journal dedicated to social scientific work on the body: *Body and Society*.

Some of these works have drawn on phenomenological approaches to the study of the body, i.e. those focusing on lived experience. These have been particularly influenced by Merleau-Ponty’s (1962) seminal work exploring the phenomenology

of perception. Here, Merleau-Ponty seeks to collapse distinctions between mind and body, and also subject and object, by emphasising the embodied nature of perception. To perceive is not to internalise an objective and pre-given world, but an active process drawing on memory, past experience and judgement. The act of perception is thus also an act of interpretation (1962: 33), ‘ending’ in objects, rather than beginning with them.

The conceptualisation of the body proposed by Merleau-Ponty, of the ‘body-subject’, a term acknowledging the entwinement of mind and body, subjectivity and materiality (though which notably still discusses this in such dichotomous terms), has been appropriated in subsequent work. The anthropologist Csordas for example, explains that the body should not be seen as an object to be studied in relation to culture, but as the ground of perceptual processes, and conceptualised as at the very root of culture, as well as the self (Csordas, 1990; 1994). This position echoes further anthropological rejections of mind/body dualism, which often demonstrate the cultural specificity of this understanding of human experience. Scheper-Hughes and Lock (1987) for example, evoke the concept of the ‘mindful body’ to describe how bodies are experienced not only phenomenologically by individuals, but also as symbolic of social relationships, and as shaped through social and political control. Later, Lock and Farquhar (2007) used the notion of the ‘body proper’ to signify the body conceptualised by biomedicine as a ‘discrete’ and ‘skin-bounded entity’ (the ‘object’ body), arguing instead for understandings of bodies as sites of “natural-cultural processes”, which are impossible to delimit (2007: 10). This approach, and those described above, challenge notions of bodies as fixed and somehow ‘natural’, instead emphasising the role of social and cultural context in their production.

It is in this theoretical milieu, emphasising the malleability and situatedness of bodies, that Shilling (2003) advanced the notion of ‘body projects’. This takes as its starting point a view of bodies as in a process of *becoming*. Drawing on Giddens’ (1991) emphasis on reflexivity with regards the self and one’s identity in late modernity, Shilling asserts that contemporary bodies may be “worked at and accomplished” (2003: 4). This may involve the transformation of its appearance, size

or shape, as individuals recognise the body as reflective of their self-identity. Bodies are thus *constitutive of the self* (2003: 3). Shilling (2003) uses the example of the work carried out by individuals to construct 'healthy bodies', for example by engaging in regimes of self-care including exercise and the avoidance of unhealthy foods. Research drawing on the notion of the body as a 'project' has also included a focus on activities such as bodybuilding (Monaghan, 1999) and the adornment of the body with tattoos and piercings (Sweetman, 1999).

Though important in their demonstration of the fluidity of bodies, and for attention to the contexts they inhabit, conceptualisations of the body as a project have been challenged. Lawton (2000), for example, notes that these take for granted the presence of a healthy, functioning body. Her study of hospice care demonstrated that for patients at the end of life, it was their dependent *bodies* that dictated their sense of identity (and also that of their carers) (Lawton, 2000: 107). As such, she sees a bounded, enclosed body as essential for selfhood to be realised (*ibid*: 7). Further, it can be argued that the notion of body projects, though aiming to demonstrate the entwinement of body and self, can be said to further exaggerate the distinction between mind and body, conceptualising the body as an object shaped at the will of its 'owner'.

Leder (1990), in his work *The Absent Body*, aims to elucidate why this dualistic understanding of bodily experience remains persuasive. He calls for this to be challenged, in part due to its potential to enable the oppression of social groups, including women (1990: 90). This has been linked to the privileging of the mind over the body in this schema, and its subsequent connections with other dualisms such as reason/emotion, and public/private (Williams and Bendelow, 1998b: 2; see Bordo, 1993 for a discussion of how this maps to gender dualities). Leder draws on Merleau-Ponty's notion of the lived body to demonstrate that in everyday life the experience of our body is characterised by disappearance. He explains that for the most part, both the surface and the depths of our body necessarily recede from our awareness, in order for us perceive that which is outwith the body, and to function in the world. It is this bodily absence that contributes to the dominance of dualist

conceptualisations of the body. As Leder explains, our actions and intentionality “can be attributed to a disembodied mind, given the self-effacement of the...body” (1990: 69). It is only through pain, illness or other dysfunction that the body seizes our awareness, or as he terms it ‘dys-appears’. This contributes to a dualistic understanding of the body as distinct from the mind, as at such times of disturbance the body can seem alien or ‘other’, and opposed to the self (1990: 70).

The notion of the absent body has been critiqued however, notably by Shilling, who finds a view of the physical self as ‘latent’ in everyday life incompatible with the notion of the body project (2003: 187). The theory has also been further charged with ascribing to a one dimensional, and masculine, conceptualisation of embodiment. Lupton claims that women are subject to heightened surveillance and control, both by women themselves and others, and as such may find it difficult to forget their bodies in the ways that Leder describes (Lupton, 1999b: 60). Recent work, however, has begun to dispute that this experience is unique to women (e.g. Holliday and Cairnie, 2007). Further, Leder himself recognises that the experience of pregnancy may also lay challenge to the assertion that the body only becomes apparent during pain or ‘dysfunction’ (1990: 89). As yet, how the notion of the ‘absent body’ figures in women’s actual experiences *over the course* of pregnancy has been little discussed in social science literature, with most instead emphasising the body’s return to consciousness at this time.

2.4.1.2 *Bringing bodies back*

Though we have observed scholars bringing the body into the focus of sociological discussions during the late twentieth century, it has been argued that these scholarly engagements had themselves been disembodied, focusing on the theoretical as opposed to lived experience (Nettleton and Watson, 1998; see also Lawton, 2000). In emphasising the social shaping of bodies, it was argued that the physicality of the body had become overlooked. Some such arguments came from disability studies. Though the social model of disability, an approach that saw social structures and contexts as rendering bodies disabled (Oliver, 1998), had been influential in disability rights, some authors pointed to the impaired body as being a necessary fact

of the politics and experience of disability, and “central to the lives of disabled people” (Hughes and Kevin, 1997: 326). This was also true in research with participants experiencing the chronic illness arthritis, for whom the disease afflicted not only specific regions of the body, but the totality of bodily experience, and in turn their emotions and sense of personhood (Williams and Barlow, 1998). Indeed, the study of emotions has been advocated as a means of transcending dualisms between body and mind. Emotions are at once embodied, traditionally conceptualised as private and ‘inner’ sensations, tied to corporeality (particularly women’s) (Williams and Bendelow, 1998a: xii), but also communicative, forged and shaped within social environments.

The study of the experience of pain in particular, encompassing both physical and emotional sensations (Bendelow and Williams, 1995), has been advanced as a means of bringing fresh attention to the biological body, or to what Williams describes as the “‘brute’ physical facts if not the fleshy dilemmas of our mortal existence” (Williams, 2006: 14). Attentiveness to the materiality of the body does not mean a reinvigoration of the dualisms described above, but what Williams et al (2003: 3) call “renewed dialogue” between the biological and the social, and their corresponding disciplines, in non-reductionist terms. This is a position influencing my methodological approach to this research, described further in Chapter Three. Experiences of pregnancy provide a useful lens through which to discuss these debates, being corporeal in essence, and encompassing dramatic changes to the physicality of the body. These unique encounters with corporeal, but also emotional (Warren and Brewis, 2004) transformations, provide useful examples through which to explore the relevance of debates described above. The changes to the body incited by pregnancy enable particular reflection on (potentially shifting) experiences of bodily absence (Leder, 1990), and the relationships between bodies and identities. The following section explores existing literature focusing on women’s embodied experiences of pregnancy, outlining their relevance to existing debates, and to the qualitative research in the chapters that follow.

2.4.2 Pregnant embodiment

Literature regarding the bodily experiences of pregnancy contributes to an understanding of embodiment as lived, being largely derived from interview and autobiographical accounts of corporeality at this time. These literatures, focusing on the pregnancies of individual or small numbers of women, mark a departure from many of those described in the sections above, whereby pregnancy is considered theoretically through the lens of technologies of procreation or “reproductive dramas” (Ivry, 2010: 5) such as birth.

Young’s (1984) seminal text regarding pregnant embodiment provides an autobiographical account of the experience of pregnancy. Here, she describes pregnancy as a ‘de-centring’ or ‘doubling’. For example, the sensations of foetal movements belong to another being but simultaneously to herself. A woman also exists in her pre-pregnant body image, while simultaneously inhabiting a pregnant body. Her subjectivity is thus split, laying challenge to the ‘unified’ (masculine) subject described in prior phenomenological work (e.g. Merleau-Ponty, 1962). Young therefore asserts that in pregnancy, the body is at once both subject *and* object; one is able to both observe changes occurring within, and experience them simultaneously, the boundaries between oneself and another being blurred (see also Tyler, 2000).

The inadequacy of accepted conceptualisations of subjectivity to describe the experience of pregnancy is also highlighted by Schmied and Lupton (2001), whose pregnant participants found it difficult and sometimes impossible to translate the bodily sensations and emotions they were experiencing into words. Pregnancy was experienced as ambiguous and uncertain, and for many the foetus was conceptualised simultaneously as both part of the self, and not of the self (2001: 35). Ambiguity was also a feature of Nash’s (2012b) participants’ accounts of pregnancy, particularly during the first twenty weeks of gestation. This was articulated with regards body image, the focus of Nash’s research. Participants described a disparity between the internal experiences of pregnancy, information about which they derived from biomedicine, and external experiences, which for many were absent during early

gestation. Due to the lack of visible evidence of their pregnant status, most notably a bump, many voiced concern that they may be seen as ‘fat’ due to the more subtle changes to their bodies. This concern with body image was not necessarily unique to pregnancy, with many discussing pregnant embodiment in relation to their past bodily histories and efforts to ascribe to cultural ideals of femininity (Nash, 2012: 318, see also Bordo, 1993).

Women have also articulated that pregnancy allows for a sense of ‘relief’ or ‘liberation’ with regards body image. Some participants in Bailey’s (2001) work, for example, shifted from locating femininity in the shape and size of their bodies, to locating it in the biological imperative of pregnancy, and as such felt less pressure to be slim (2001: 119). For Bailey, this represented a change in her participants’ conceptualisations of femininity in line with the bodily changes they experienced. The meanings of their bodies also changed, now seen as being ‘for the baby’ (*ibid*: 120). Reflecting authors such as Shilling, who describes bodies as “constitutive of the self” (2003: 3), it may be expected that participants’ sense of identity will be altered by pregnancy, which encompasses at times dramatic changes to the body. Whilst Bailey’s participants did experience altered awareness of their bodies and themselves, for example with regards their gendered identities, she argues that pregnancy did not effect a complete change in their selves. Rather, aspects of the self were *refracted* by the experience of pregnancy, as opposed to being altered fundamentally (Bailey, 1999). The maintenance of pre-pregnant identities is also described by Earle (2003), who interpreted her participants’ resistance to dominant discourses of the pregnant body as asexualised as a wish for their identities to remain, and be seen by others, as they were prior to pregnancy.

Related to this is a discourse commonly found in research regarding the experience of pregnancy: the desire to ‘get the body back’ following pregnancy (e.g. Bailey, 2001; Upton and Han, 2003; Nash, 2014). This indicates a sense that the pregnant body, and that immediately post-partum, is somehow discordant with their pre-pregnant selves, to which women may want to return. To facilitate this, some women in existing research, in contrast to those seeing pregnancy as a time of ‘liberation’

from such pressures, have articulated the efforts made to “work on” their bodies, through their diets and exercise, during pregnancy (Upton and Han, 2003: 678). For some, exercise during pregnancy has also been discussed in terms of getting “fit for birth” (Nash, 2011a: 458). These practices, along with the changed diets adopted by women, are often encouraged in the pregnancy literature provided to women, touched on above in Section 2.2.3.1. Efforts made in this regard (which may have motivations aside from a desire to ‘protect the foetus’ (see Markens et al., 1997)), have been highlighted as important elements of the ‘performance’ of pregnancy (Neiterman, 2012).

It is of note here that through their discourses of ‘working on’ the body, and ‘getting the body back’, the women represented in these studies reproduce a dualistic understanding of the mind and body which, as we have seen, has often been resisted by social scientists. This is most evident in descriptions of pregnancy that see the body as uncontrollable. For example, as a result of experiences of nausea in the early months of gestation, and the body’s changing shape, the eleven women in Warren and Brewis’ (2004) study felt they had lost control of their bodies. As also demonstrated by Bailey (2001), this could be experienced negatively, but for some was pleasurable. Warren and Brewis (2004: 232) therefore argue that pregnancy poses a contradiction to the notion that individuals have jurisdiction over their bodies and the power to sculpt them, as argued by Shilling (2003). Carter (2010) also found a discourse of lack of control amongst childbearing American women. Nevertheless opportunities were also provided at times for women to construct themselves as in control, for example when describing their relationship to the pregnancy as opposed to that of their partners’.

2.4.3 Summary

This section has outlined debates in sociology and anthropology surrounding the body and embodiment. This provides important context for contemporary discussions regarding the pregnant body, which challenges accepted understandings

of subjectivity: as Young (1984) describes, the pregnant body is at once subject and object.

Existing literature has largely pointed to the fact that during pregnancy, a woman acquires a changed, often increased, awareness of the body. This may be as a result of changes to the experience of daily activities, such as sitting or brushing past objects, caused by altered bodily boundaries (Young, 1984, Tyler, 2000). Existing accounts have also demonstrated that embodiment may be experienced in diverse ways at different points in pregnancy. As we have observed, in early pregnancy there was a degree of ambiguity and ‘in-betweenness’ with regards women’s attitudes and experiences of their pregnant bodies (Nash, 2012). This has not been sufficiently captured in existing literature. This is partly owing to the fact that there is variation with regards the point at which women have been interviewed in existing studies. For example, only one of those in Warren and Brewis’ sample was pregnant at the time participants’ accounts were obtained. The fluidity of pregnant embodiment for individuals *over the course* of gestation, and *as it occurs*, is rarely discussed in existing literature. As described above, this is particularly true of early pregnancy. Further, though discourses of risk loom large in the contemporary experience of pregnancy, little literature has described how the experience of risk and uncertainty ties to embodied experience, or the influence this has on how women relate to their pregnancies (cf. Rothman, 1988).

2.5 Conclusion and research aims

This review has outlined the context in which the experience of pregnancy takes place in the UK today. As we have observed, past scholars have outlined the historical movement of pregnancy from the care of midwives without formal training, into the hands of medical professionals. The academic exploration of this process, largely emerging in the 1980s, can be aligned with feminist concerns of the time, which questioned the masculine bias inherent in science and its related disciplines. A wider concern with the dominance of the medical profession, and the processes through which aspects of the human condition become incorporated into the care of medical professionals, has also contributed to this task.

It is argued that in contemporary European and North American contexts, pregnancy is depicted as potentially pathological and in need of intervention. This is evident in the discourses of risk surrounding both the nine months of gestation and childbirth, and regimes of medical interventions offered to women during this time. These, it has been argued, have altered women's experiences of pregnancy, whereby medical and technological ways of knowing have become privileged over women's embodied knowledge of their pregnancies. An important consequence of technological intervention has been the creation of the 'public foetus', to which women's reproductive rights may be subordinated, and to which women are expected to 'bond', thus extending parenthood backwards into the prenatal period.

We have also observed that pregnancy presents an interesting case through which to discuss sociological and anthropological approaches to the body and embodiment. The experience of gestation has troubled traditional understandings of subjectivity, but also debates within the social sciences seeking to destabilise the mind/body dualism characteristic of historical discussions of the body.

Several research aims emerged based on this review of existing literature in the field of pregnancy. Firstly, I aimed to explore the experiences of pregnancy for individual women *over time*. This review has outlined that experiences of pregnancy demonstrate fluidity and contingency over the course of gestation, both in terms of the body and the interventions women experience. Relatively few studies, however, follow women through pregnancy, with many often focusing on their experiences of specific encounters or interventions (notable exceptions are Ivry, 2010; and Han, 2013 who both undertook ethnographic research with women during pregnancy). This research therefore aimed to follow women's experiences of pregnancy over time, capturing their varying engagement with biomedical interventions, as well as how these shape and are shaped by embodied experiences as they occur.

Related to this, I set out to explore women's interactions with a range of technologies and interventions during pregnancy, including those not commonly discussed in

existing literature. These include the Doppler machine, used by health care professionals to assess foetal heart rate, and online resources such as Internet forums and visual depictions of foetal development. Though ultrasound technology is reported as having a significant impact on women's experiences of pregnancy, and has had important consequences for the representation of the foetus as person, its reification in existing literature is perhaps silencing women's accounts of the wider range of resources and interventions they experience throughout gestation.

A further area for exploration was women's experiences of early pregnancy. As indicated above, both embodied experience and conceptualisations of the foetus seem to be particularly uncertain during this period of gestation. This period of time remains under-explored in existing literature, with research that does consider early pregnancy often engaging with women's retrospective accounts. I aimed to capture women's accounts of early pregnancy, again at the time they are experienced, to explore any such accounts of uncertainty. This is especially pertinent with regards the foetus, often described in terms of a singular and accessible entity in existing literature, to which women can be 'bonded'.

The longitudinal (over the nine months of gestation) method adopted by the research that follows was chosen to attend to these considerations. This approach will be outlined in the following chapter.

Chapter Three

Methodology

3.1 Introduction

This chapter describes my research methods and practice. I outline the theoretical and philosophical foundations underpinning the approaches and methods used in this research. This is in terms of my choice of a qualitative methodology, my use of in-depth longitudinal interviews, and my analysis. I also describe a pilot study undertaken to inform my choice of participants and design for my main study, on which Chapters Four, Five and Six of this thesis are based. This pilot work shaped the sample of women with whom I conducted interviews, and the questions used during the interview process. This initial study also informed the techniques I used to analyse my interview data.

Integral to any research are ethical considerations, though these were particularly pertinent in my research due to the fact that I would be meeting women prior to their twelfth week of pregnancy. The reasons for this are described below. Ethical issues also arose with regards my relationship with participants. These unique research relationships, and my role in the interview process, required constant self-reflection and reflexivity. This is increasingly becoming an integral aspect of qualitative research (see for example Finlay and Gough, 2003; Roulston, 2010). How this was maintained is described throughout this chapter, and evidenced throughout the remainder of this thesis.

3.2 Epistemological and ontological foundations

As discussed by Hughes, the methodological tools and procedures used by researchers reflect “particular commitments to particular versions of the world, and

to knowing that world” (1990: 11). It is therefore important that researchers recognise the philosophical assumptions they take with them into the research process, for, as Hughes suggests, these will shape the selection of their research interests, and the ways in which they choose to gain knowledge of these interests. This thesis is grounded in the academic discipline of sociology, chiefly medical sociology, and also draws on relevant scholarship from science and technology studies (STS) and medical anthropology. In contemporary European and North American academic practice, these fields are often associated with a social constructionist ontology, commonly invoked in discussions of the status of medical knowledge. Sociological theory concerning processes of medicalisation (Conrad, 1992), disability (Oliver, 1998) and the construction of scientific facts (Latour and Woolgar, 1986) has demonstrated that medicine’s key objects of study – i.e. disease and the body – are not fixed entities, but shaped by (and simultaneously shape) their social context. Strong social constructionist approaches see reality as derived through and maintained by social interaction and discourse alone (Berger and Luckmann, 1967). For this reason, research in these fields has traditionally adopted an interpretivist approach, whereby focus is upon individuals’ understandings and experiences of their social world(s). This is as opposed to positivist approaches to social science, which attempt to derive objective data about the social world, the laws of which are seen as knowable in a manner equivalent to those of the natural sciences (Pascale, 2011).

In line with my disciplinary background, my ontological approach to this research broadly aligns itself with a constructivist or interpretivist paradigm. However, recent debates surrounding a key area of my research, the body, have made me reluctant to subscribe to a ‘strong’ constructionist position (e.g. Bloor, 1976). Simon Williams (1999) remarks that sociological discussions of the body as discursively produced have disembodied and dematerialised the biological body. This has been to the detriment of areas of study such as disability, an experience where individuals’ encounters with diversity and difference are embedded in *real* impaired bodies (Williams, 1999: 811). The experience of the biological body is a fundamental aspect of my research, and as such embodiment, one’s perceptual engagement and mode of

presence in the world (Csordas, 1993), occurring in and through a material body, is a key theoretical concern. It is important that my methodological approach therefore leaves room to explore the squirms, stretches, and swelling of pregnancy, as well as the hormonal changes women may articulate that they are experiencing (some of which are materialised in the pregnancy test). For this reason my approach acknowledges that these biological processes ‘really’ exist, a position allowed for within a critical realist ontology.

Critical realism, an approach advocated by Williams (1999), maintains elements of ontological realism - the acceptance of a reality existing beyond our perceptions, theories and representations of it - but also recognises that this reality can only be accessed through fallible theories, which are partial and situated (Cruickshank, 2003). In line with Williams (2006), I believe that an openness to realism, and dialogue with scientific disciplines such as biology, has much to offer if sociologists wish to address individuals’ corporeal realities. However, recent work has complicated the nature of the reality espoused by critical realism, questioning notions of this reality as singular and independent. Law (2007), drawing on Mol (2002), asserts that though reality is often made singular in practice, practices including medical procedures (Mol’s work considered those used to diagnose atherosclerosis) can and often do create *multiple* rather than single objects or realities. Whilst I am aware of these debates, I do not align myself with this position.

My ontological approach is therefore situated where critical realism and social constructionist frameworks overlap (Williams, 2006; Pascale, 2011). As highlighted by Law (2007), I understand that the social worlds I am researching are ‘messy’, and as such cannot be made to fit into unified methodological paradigms. Instead, I see such perspectives as useful *resources* for conducting qualitative research (Maxwell, 2012).

My epistemological stance again draws on interpretivism, in that I see individuals’ accounts as providing a legitimate way to explore the social world. These accounts are complicated and context dependent, and in order to understand some of this

complexity, I felt it important to seek in-depth accounts of individuals' understandings and experiences. My research focus, formulated in response to my review of the literature, has a strong emphasis on individual experience. I aimed to understand experiences of pregnancy and the foetus from the point of view of pregnant women themselves. This is especially salient during the first months of gestation, when a woman herself is the only individual to have any tangible experience of her pregnancy. I therefore sought in-depth accounts from women, during pregnancy, to gain understanding of their experiences of gestation and the foetus within.

Qualitative methods were suitable for this task because they are characterised by flexibility and sensitivity to the social context in which they are produced (Mason, 2002). I chose to use semi-structured interviews in particular because they allowed participants to expand on their answers to my questions, and for the introduction of unexpected themes deemed relevant by my research participants. This element of interviewing touches on the constructed nature of interview data. I adopted an approach which understands respondents as continually piecing together the information they convey to the researcher, actively constructing their experiences *during* the interview process, as opposed to simply relaying a pre-existing account (Holstein and Gubrium, 2004: 145).

Similarly, interviewers are not invisible neutral entities, but influence interaction in the interview setting. This may be through their manner of questioning or presentation of self. Though some researchers do adopt a positivist approach to interviewing, requiring attempts at the elimination of the subjectivity of the interviewer (Kvale and Brinkmann, 2009), many scholars now embrace the active role played by researchers in the creation of data. In line with constructivist principles, this can be seen as a feature of all forms of research, including those based on quantitative data. My use of semi-structured interviews, because of the obvious and instrumental involvement of the researcher, required me to explicitly acknowledge my role in the creation of data through considered reflexivity. This will be observed below in Section 3.3, and throughout the chapters that follow.

The fact that the data derived from interviews is unavoidably specific to the context in which it is created has led postmodernist scholars to claim that interview data cannot be understood as a reflection of events external to the interview. Accounts derived during the interview are seen as local and situated, and capable only of producing knowledge about the interview encounter itself (Alvesson, 2002). This view is associated with strong constructivist approaches, which consequently see the application of criteria such as reliability and validity as inapplicable to interview research (Seale, 1999). In contrast, a critical realist approach, in its acceptance of a reality external to the interview encounter, sees interview talk as providing access to rich accounts of events and experiences representing social reality (Smith and Elger, 2012: 14). This understanding of interviews supports a case for, as far as possible, standardising the interview process within a research project in order that comparison can be made between participants. For me, this included asking interviewees questions under the same broad topics, and avoiding leading questions. I also aimed to be transparent in the reporting of my methods and analysis, which necessitated reflection on how these may be influenced by my own background and beliefs (Snape and Spencer, 2003: 20). The steps taken to ensure the quality of my research, and the maintenance of reflexivity, are addressed below. Such measures are taken in the pursuit of rigour in qualitative research. This is particularly pertinent for researchers in health sciences, who often must defend their methods to those working within positivist paradigms.

Having laid out the ontological and epistemological rationale for my use of qualitative research, specifically semi-structured interviews, I shall now turn to the methodological traditions on which my research design is based.

3.3 Methodological influences

There are many different approaches to qualitative interviewing, which shape all aspects of the research process including the interview itself, transcription, and analysis. The methodology adopted for this research, like that of Denzin and

Lincoln's (2011) 'bricoleur', is influenced by several existing qualitative methodologies, including phenomenological, feminist and narrative. Feminist methodologies approach research with an explicit acknowledgement of the gender biases present in everyday life, and attempt to expose and challenge these (Ramazanoglu and Holland, 2002: 12). Narrative methodologies consider interview accounts as stories, and may approach data derived in interviews by considering the events described by participants in relation to the wider account they provide (Elliott, 2005: 3). The final influence on my methodology has been phenomenological methods of data collection and analysis, which focus on the minutiae of lived experience, situating this in the wider context of an individual's life. Here, emphasis is placed on the meaning that specific events or experiences hold for participants (Smith, 2009).

While all have relevance for my research, I am resistant to firmly situate myself within any one of these approaches. For example, though my research focuses on the voices of women, and on an experience unique to women's bodies, I have not committed myself to an explicitly feminist methodology (within which diverse approaches exist). This is in part because I do not wish to inadvertently appropriate data to fit the aims of feminist research, or to silence experiences which may challenge feminist agendas (Opie, 1992). However, I do take from feminist methodology an awareness that gender inequality underlies my interviewees' experiences of pregnancy, for example as embedded in the science on which their encounters with medical institutions and interventions are based (see Harding, 1986; 1991). I also take from feminist methodologies an approach to interviewing which allows both researcher and participant to invest their personal identity into the interview encounter, and minimises hierarchy in the research relationship (Oakley, 1981)³. This will be discussed further in Section 3.7.3.

Though my data collection did not adhere to a strictly narrative approach, I made sure to allow participants to tell me their stories in interviews. I was interested in the

³ Though originally conceived of in response to interview techniques associated with a 'masculine paradigm' (Oakley, 1981), it is increasingly recognised that this is not a distinctly feminist approach to interviewing (Ramazanoglu & Holland, 2002: 16).

context in which my participants' pregnancies took place, and as such encouraged the introduction of women's biographies through the use of open-ended questions, designed to produce rich descriptive accounts (Elliott, 2005). This was facilitated by interviewing my participants more than once. I also drew on narrative techniques during my analysis, described later in this chapter. My emphasis on interpretation throughout interviews, both of my participants' interpretations of their experiences of pregnancy, my interpretation of their narratives, and my focus on women's lived experiences of pregnancy through their bodies, reflects some of the principles of phenomenological approaches to qualitative research (King and Horrocks, 2010: 179).

By acknowledging this emphasis on interpretation, I recognise that the output of my research is a situated account, which necessitates awareness of my role in the research process. This includes with regards my motivations for conducting research, my influence on the interview setting, and how my subjectivity has shaped my methods and practice with regards analysis. The contemporary emphasis on reflexivity in qualitative research, described as the researcher's "thoughtful, conscious self-awareness" (Finlay, 2002b: 532), reflects the recognition in the social sciences of the partial and provisional nature of knowledge claims, and related to this, "the presuppositions inherent in the position of the 'objective' observer" (Bourdieu, 1990: 27). Throughout this thesis, I intend to bring transparency to the research process by making explicit my theoretical commitments, ontological and epistemological assumptions, and emotional responses to my interview data. This has been aided by constantly reflecting on my experiences of conducting research through written notes. My engagement in reflexivity is not to "reveal bias" or demonstrate that "all knowledges are arbitrary", a position criticised by Lynch (2000: 47). Instead I have used it as a methodological tool to gain further perspective with regards my data, with the aim of generating a rich and multi-layered analysis (Finlay, 2002b). A reflexive approach, which acknowledges the influence of the personal in research relationships and analysis of participants' narratives, also contributes to the project of accountability and thus the ethical robustness of research (Doucet and Mauthner, 2002).

As part of the project of reflexivity, this chapter outlines some of the ways in which my biography, feelings and beliefs have influenced the design and practice of my research. Here, I would like to address an issue related to my methodological and theoretical approach as grounded in medical sociology. This academic background has presented me with a dilemma, as although I am accustomed to this area of sociology, and find it appropriate to shed light on many aspects of the experience of pregnancy, I am reluctant to discuss pregnancy in terms of an illness, or to reinforce the location of pregnancy in the domain of medicine. I have drawn on medical sociology, however, because of the commonalities in these experiences, particularly regarding encounters with medical professionals, and also in the application of visualising technologies to women's bodies, most notably ultrasound. Noting instances of conflict in my research diary has allowed me to consider any effect this predicament may have had on the process and analysis of my interviews.

3.4 Pilot Study

Prior to beginning the qualitative semi-structured interviews on which this thesis is based, including the application for ethical approval and formulation of topic guides, I carried out a small pilot study. Pilot studies are sometimes used as a 'trial run' of research instruments, such as topic guides, in preparation for a large scale research project (van Teijlingen and Hundley, 2001). The pilot work I conducted aimed to gain women's feedback regarding some of the questions and concepts I planned to take forward into the main research project, developed following my literature review. I present some of the data derived from this small study below, to demonstrate how it informed the development of the research on which this thesis is based. Data from my pilot research are not included in any further chapters.

I decided that my pilot study should be based on focus groups due to the potential they provide for participants to generate their own questions through discussion, and to pursue their own priorities in their own vocabulary (Barbour and Kitzinger, 1999). This was important because the pilot study was an exploratory exercise; I wanted to

hear the views and attitudes of my participants in the absence of a fully structured topic guide. Indeed, focus groups ideally provoke animated debate between participants, allowing for minimal researcher involvement (Barbour, 2006).

3.4.1 Recruitment

Because this was a pilot study, a strictly defined sample was not sought to take part in focus groups. Nevertheless, as my semi-structured interviews would focus on the lived experience of pregnant women, many of whose bodily changes can be known only to them, I decided that it was important at all stages of my research to interview women who had experienced pregnancy at some point in their lives.

Following ethical approval from the University of Edinburgh Research Ethics Committee, recruitment and focus groups took place between February and November 2012. The easiest form of recruitment was for the first focus group, arranged through contact with friends in a department of the University of Edinburgh. As all women who took part in this focus group knew me, and all worked in the same department, it was extremely easy to enlist their support, arrange a suitable time to meet, and agree on a venue. Though the most effective form of recruitment, the use of friends in interview research entail unique issues to consider, including the potential for the disclosure of information which may have remained confidential with another interviewer (Cotterill, 1992). I was therefore mindful of this when transcribing our encounter. The second focus group also took place at a time and venue that was easy to arrange. This group were a ‘captive audience’ (Bailey, 1994), formed of members of an antenatal class who I sourced through a contact at the National Childbirth Trust. The focus group took place immediately after their class, and in the same venue (though one class member declined to participate).

The third focus group relied on a mixture of recruitment methods, including the publication of a small recruitment request in the Edinburgh National Childbirth Trust newsletter. One participant, who saw this article, approached me, whilst another was pointed out to me by a colleague who knew of her pregnancy. The last participant

responded to a departmental email. Because all focus group participants had different working hours, and were located at various locations around Edinburgh, it was difficult to arrange a time and venue for this focus group.

The composition of my three focus groups was as follows:

FG1: Three women in their thirties with small children. One had experienced three pregnancies, the other two participants had experienced one.

FG2: Eight women in their thirties, all pregnant for the first time.

FG3: Three pregnant women in their thirties, one of whom was pregnant for the second time.

Though ethical approval was sought for a pilot study of five focus groups, the difficulties posed by recruiting women to form a discussion group, highlighted above, and the need to shift my concentration from my pilot study to recruitment for my main interviews, meant that I ended my pilot study after three focus groups. This was also because I felt these had provided sufficient data on which to base my sample selection and topic guides for my main study, enabling me to proceed with my application for ethical approval, and recruitment for the semi-structured interviews.

3.4.2 Findings and implications for main study

Once I had prepared the transcripts of my recorded focus groups, I coded these with the help of NVivo 9, a brand of computer assisted qualitative data analysis software (CAQDAS). I used coding as a process to identify common descriptive or theoretical ideas in the transcript (Gibbs, 2007: 38), and highlighted these using NVivo. A function of the software allowed me to view the most common codes, which I then developed into themes using my knowledge of existing literature. My analysis, however, was not as data led as that used in my main study, due to the fact that my pilot research was used to address specific concerns such as the way in which participants discussed the foetus, and also the suitability of my proposed topic guides.

3.4.2.1 A note on terminology

A key concern emanating from my literature review related to uncertainty regarding how women speak about the foetus they are carrying. I was keen to speak about pregnancy on women's own terms during the interviews, rather than imposing an understanding of pregnancy I had developed after engaging with relevant literature. This aligned with my interpretive approach, and my commitment to an inductive form of analysis. The latter is used to describe the process whereby themes and concepts used to address research questions are derived *from* data, as opposed to being formulated prior to empirical research (Mason, 2002: 138). Social science literature focusing on pregnancy largely uses the term foetus (Ginsburg and Rapp, 1995; Morgan and Michaels, 1999; Rapp, 1999). This often reflects a political stance: discussion of the foetus in terms of a 'baby' is often associated with anti-abortion rhetoric. However, the literature I explored based on discussions with women themselves about their experiences of pregnancy seemed to suggest that pregnant women referred to a 'baby' (Mitchell, 2001; Taylor, 2008; Nash, 2012a). Indeed, when interviewing participants for her study, Mitchell used this term in the questions she posed (e.g. 2001: 71).

I had already resolved to use the term 'foetus' in my written work. As we have seen, several terms have been mobilised by existing authors. I rejected the term 'unborn', used by Lupton (2013b), as this implies that the entity within women *would* be born. Of course, this is not always the case (i.e. in the examples of early pregnancy loss or abortion, which Lupton herself highlights (2013b)). My rejection of the term 'baby' is connected to my concerns with its potential to subjugate women's rights with regards their decision to terminate their pregnancy. A compromise perhaps was Markens et al's (2010) use of "foetus/baby". However, this implies that only two forms of imagining of the foetus are possible, which are dichotomised in Markens et al's usage. From my reading however, it seemed that women's conceptualisations of the entity within had the potential to be 'blurrier' than this. Though remaining an ambiguous term, I thus chose to use the term 'foetus', and at times 'foetal entity' to signify the material entity, with a potential to develop into a baby, within women's

bodies during pregnancy (see also Michaels, 1999: 114). Though a medically derived term, it is also understood in common parlance. This can also be said of other terms invoked during my thesis, such as ‘uterus’ and ‘gestation’. Nevertheless, though I had decided to use ‘foetus’ in my writing, during interviews I did not want to contradict women’s conceptualisations of the foetus as a baby, if this is what they understood themselves to be carrying.

My focus group research found that the terms used to identify the foetal entity within was fluid. The term baby was used in all three focus groups, and the term foetus in two. Additional terms also arose for the foetus, including ‘he’ or ‘she’, ‘he-she’, ‘daughter’ and ‘it’; in two focus groups the same individual switched between the terms ‘he’ or ‘she’, and ‘it’ during the discussion. An analytical point of interest was the way in which one participant used the language of a ‘foetus’. Responding to another participant’s descriptions of trying to imagine what the foetus (which this participant referred to as her ‘daughter’ and ‘our child’ during the focus group) will look like, Eliza explained:

I don’t wanna think like that, because I’m trying not to...now it’s just a foetus and then hopefully in a few months, you know, I will, I will have a baby.
Eliza⁴, FG3

This understanding of the foetus took place in the context of her previous pregnancy, which almost resulted in a stillbirth during a distressing labour. A similar use of language was also invoked during FG1, where a participant discussed her experience of miscarriage:

It was the loss of a pregnancy rather than a baby.
Lauren, FG1

⁴ Pseudonyms have been used for all participants; further strategies to ensure confidentiality in my research are discussed in Section 3.6.

Such strategies regarding ways of relating to the foetus in the face of uncertainty, or a previous pregnancy loss, re-emerged as an important theme in my main study. This will be observed in the subsequent chapters of this thesis.

My focus groups therefore demonstrated that the terms used to describe the foetal entity might be reflective of a particular positioning of the speaker in relation to the foetus they carried. For example, Lauren demonstrated that during the (early) stage of pregnancy when her miscarriage occurred, there was no baby to speak of, only a 'pregnancy'. These discussions show that the use of these various terms may be of significance to my study of women's experiences of the foetus. Terms used by women varied depending on factors such as an individual's reproductive history, whether they were currently pregnant, and whether they had knowledge of foetal sex. Importantly, they also seemed to vary according to the stage of pregnancy participants were experiencing, as demonstrated by Brenda:

We're all much further than twenty weeks [gestation], and now it's more of an actual human being, like a big, a big baby.

Brenda, FG2

Such talk reinforces the need for a longitudinal interview approach, initially suggested by my review of the literature, and discussed further in section 3.7.1.

Several issues of interest therefore emerged through paying attention to the various terms used by women to refer to the foetus. These influenced the formulation of topic guides used in my main study. The fact that the use of such terms is fluid and flexible also demonstrated to me that no single term would be most appropriate to use in interviews. Instead I resolved to reflect back the terms used by my participants during our individual encounters.

3.4.2.2 A range of interventions

My focus group research also allowed me to become more familiar with the medical interventions experienced by women as part of their NHS antenatal care. Having never experienced pregnancy, the package of care women undergo during gestation

was relatively unknown to me. I was aware of women's encounters with ultrasound scans, but not of how often women see their midwife, or of the timing of any other technological interventions they receive. From my focus groups I learned that the contact with midwives my participants received differed between individuals. In FG2 in particular a lot of time was spent discussing the differences in frequency of contact participants had had with their midwife, and whether they had seen the same midwife on more than one occasion. I realised that in my semi-structured interviews I would not be able to take the timing of midwife appointments, or the interventions experienced during each appointment, for granted, and therefore included questions about each separate appointment in my topic guides. These were formulated with reference to an NHS Scotland document outlining pathways for maternity care (NHS Quality Improvement Scotland, 2009) (see Appendix I).

Discussion of medical contact in focus groups also challenged existing literature heralding the ultrasound scan as an important site for the experience of maternal-foetal bonding (Taylor, 1998; Mitchell, 2001). Two participants in separate focus groups asserted that looking at the scan was like seeing a "TV screen", with one woman describing the scan picture as "meaningless" (Lucy, FG1), and another explaining:

It's on a TV screen up there, so it's almost like it's not you...I mean it, I found it difficult to say that is in here [pointing to bump].

Clare, FG1

Further, some participants in this pilot study privileged embodied or aural knowledge of the foetus over the visual knowledge provided by the ultrasound scan. Despite a wealth of literature focusing on the ultrasound scan and its transformation of pregnancy for women (Fletcher and Evans, 1983; Mitchell, 2001; Taylor, 2008), the experiences related by some of my focus group participants indicated that an alternative reading of the relationship between ultrasound and a woman's connection to the foetus is perhaps required. I therefore resolved that I would not privilege discussion of the ultrasound scan in my interviews, but also ask about women's experiences of technologies including the Doppler machine, which enables women to hear the foetal heartbeat at their midwife appointment. Focus groups did, however,

predominantly highlight that the ultrasound scan helped women, and their partners, to accept the reality of their pregnancy, in line with existing literature (Mitchell and Georges, 1998; Nash, 2007; Draper, 2002). One participant in FG2, for instance, explained that she took five pregnancy tests, but did not believe she was pregnant until this was confirmed by the first ultrasound scan. I therefore felt it important to ensure that my first interview with participants took place before the first scan, in order to discuss how women conceptualise the foetus at a time when they may not be fully convinced of their pregnancy.

3.4.2.3 *Choosing pregnancies*

Finally, my focus group research helped to shape the selection criteria for my study sample. In research concerning pregnancy conducted for my postgraduate degree in public health, I had included women who had recently given birth in my sample. I was aware though, that their perceptions of risk to the pregnancy may be transformed by discussing pregnancy retrospectively, after having given birth to a healthy baby (Ross, 2012). For my PhD research, I was keen to explore women's experiences of *early* pregnancy, which represents a gap in existing literature. As the first trimester of pregnancy is a time when the discourse of risk is particularly pervasive in the literature provided to women, due to the highest number of miscarriages occurring at this time (Gabbe et al., 2012), I therefore felt it was important to speak to women *during* their pregnancy to fully appreciate their engagement with these discourses of risk. This was confirmed for me during my focus group with mothers of small children, none of whom were pregnant at the time. Despite the participants knowing from the outset that my focus was on pregnancy, towards the end of the focus group discussion focused on their post-pregnancy experiences. One participant explained:

It says a lot about what we think about pregnancy, that we're talking about the babies...[pregnancy] is a transportation to what comes afterwards.

Lauren, FG1

Lauren seemed to suggest that some experiences of pregnancy may be overshadowed after birth. Due to a theoretical concern with embodiment, I consequently decided my research must focus on women's *pregnant* bodies, to fully appreciate the

corporeal changes they were experiencing. Such changes could be as small as their nails growing at an increased rate or bleeding gums, and had the potential to be overlooked after giving birth. I also decided to only interview women experiencing their first pregnancy for my research. This is related to the reasoning above, as illustrated by another member of FG1:

When you've got subsequent babies [pregnancy is] just such an inconvenience, you're just not thinking about it, the baby at all, it's just something that you've got to go through...you're aware of it all the time but you can barely think about it.

Amy, FG1

I wanted my interviews to fully engage with my participants' experiences of pregnancy, particularly of the foetus, and decided that this may be difficult to do if women are not 'thinking' about their pregnancy, which Amy suggests may be the case for women with small children (though not 'thinking' about their pregnancy remained a feature of my interviewees' narratives, even though they were experiencing first time pregnancies. This is discussed particularly in Chapter Six).

Having touched on the rationale for some aspects of my chosen study sample, I now move on to discuss the data collection and subsequent analysis conducted in my main study.

3.5 Main study sampling and recruitment

As discussed, my pilot work proved invaluable to the selection of my sample, formulation of topic guides used in my main study, and to becoming more familiar with the medical interventions and artefacts experienced by women during pregnancy. The process of data collection on which this thesis is based is described below.

3.5.1 Sampling

In response to my research questions, which emphasise women's individual and lived experience, it was important that the study population for my PhD research was

composed of women who had been through a pregnancy. As described in the previous section, following my pilot study and review of existing literature, three additional criteria emerged. Firstly, that my interviewees would be experiencing pregnancy *at the time* of my interviews. Secondly, to investigate the potentially fluid nature of women's experiences of pregnancy and the foetus, I would need to interview my participants more than once during their pregnancy, with the first interview taking place before their twelve week scan. And finally, it was desirable that I heard the narratives of women experiencing their first pregnancy. My sampling strategy would therefore be 'purposive', with my respondents chosen based on particular features, enabling the exploration of the themes and puzzles integral to my research aims (Mason, 2002).

Beyond these criteria I did not attempt to define the composition of my sample. This includes in terms of classifications such as age, social class or ethnicity. Though most quantitative, and indeed many qualitative, studies aim to reflect the diversity of the wider population, I felt that this would be inappropriate for my research. My research focus does not aim to make comparisons between variables such as social class; further, even within such a category experiences would vary markedly according to other characteristics with which it intersects, including reproductive history, age and cultural background. In accordance with Mason then, I did not wish to select participants according to such classifications, which have the potential to reduce complex biographies to a single static measure (Mason, 2002: 129). This echoes the spirit of my ontological position and analytical approach (discussed in detail below), whereby focus is on trying to make sense of rich and complex individual experiences. This is especially salient due to the fact that one of my research interests, experiences of early pregnancy, was an emerging area of study. My analytical focus thus did not become clear until later in the research process, and required a holistic approach to each participant's narrative, as opposed to efforts to make comparisons between participants, or to wider individuals. My research had the potential, however, to identify areas for further study, which may benefit from a more comparative approach. These are discussed further in the final chapter of this thesis.

This inductive approach was commensurate with the longitudinal methods used in my study, which entailed the possibility of shifting research concerns. Due to the importance I ascribed to undertaking multiple interviews with participants, I restricted the number of participants to fifteen (resulting in forty five interviews in total). This is in accordance with Ritchie et al (2003), who suggest that the quality of data collection and analysis can be compromised if the number of interviews in a study exceeds fifty. This was especially salient for my research, as I anticipated that analysis would be particularly time consuming. This was owing to the fact that I would be required to analyse change longitudinally within each participant's set of interviews, and also consider similarities and differences in experiences horizontally across interviewees.

Having decided upon the criteria against which I would seek participants, recruitment began in November 2012. This adopted a flexible approach, due to the predicted difficulty of locating and meeting participants during their first trimester of pregnancy.

3.5.2 Recruitment

To decide upon the best recruitment strategy, I first turned to existing research to assess the success of various methods used to recruit women in their first trimester of pregnancy. I could not find any relevant qualitative studies. One helpful paper came from a Canadian prospective study examining exposure to chemicals during pregnancy. The authors drew on thirteen methods to recruit participants. Of these, they found posters, study booth presentations and online advertising to be the most successful methods of generating interest in their research (Webster et al., 2012). I also explored the option of approaching women in community health centres, following their eight week booking appointment. This, however, would have required cooperation from midwives, whose workloads I did not wish to add to. Additionally, I did not want to encroach on their patients' space and time. There were also issues regarding confidentiality, which may have been breached should a woman's friends or family see her talking to me. As discussed, this is especially

significant during the first trimester of pregnancy. Further, though a similar approach may have yielded a more diverse sample, the study quoted above found a similar active method of recruitment to be one of their least successful methods, relative to the large amount of time and effort it required. Following these considerations, I decided to use posters, Internet message boards and social media as my primary methods for recruiting participants.

My poster (see Appendix II) was created with reference to that used in Webster et al's (2012) study. I wanted the posters to be displayed in locations that would reach a large number of women of working age, so placed four in staff rooms in supermarkets around Edinburgh. I also sent four posters to various universities within a reasonable travelling distance of Edinburgh, and placed two in University of Edinburgh buildings. I envisaged these being placed in large offices, and chose universities in the hope that potential participants would be more receptive to taking part in academic research.

My main focus, though, was online recruitment methods. I was familiar with websites such as *mumsnet.com* and *netmums.com* due to previous research I had conducted with women experiencing pregnancy (Ross, 2012). These were also mentioned in two of the focus groups conducted for my pilot study. Online forums such as *mumsnet.com* allow members to anonymously join, and begin, conversations on subjects of their choice, though here these are largely related to parenting (Skea et al., 2008). It seemed that such sites provided a source of information and support for women during the early stages of pregnancy in particular, when many kept their pregnancy a secret. After seeking permission from website administrators, I posted details of my study in the pregnancy themed 'message board' areas of *netmums.com* (November 2012), *mumsnet.com* (November 2012), *babyexpert.com* (November 2012), *pregnancyforum.co.uk* (January 2013) and *pregnancyforum.org.uk* (February 2013).

The use of such websites for research recruitment purposes is understandably seen as intrusive by some of these sites' users and moderators (Mendelson, 2007), and as

such conditions are often imposed upon posting a message. For example, I was only able to post on one occasion on *pregnancyforum.co.uk*, and once a month on *netmums.com*. *mumsnet.com* implements a fee for researchers wishing to recruit study participants. Conditions such as these made recruitment difficult, but not impossible, and further contributed to the ethical integrity of my research. Two additional sites, *babycentre.co.uk* and *emmasdiary.co.uk* were not used, due to my inability to contact a relevant administrator (despite several attempts). My post included a brief introduction to my study (see Appendix III), and a link to a website I constructed to provide further details about my research:

<http://edinburghpregnancystudy.wordpress.com> (see Appendix IV for a ‘screen shot’ of the website). I also was able to introduce myself on the website, and include a photo and links to my department profile page. It was hoped that this would demonstrate the legitimacy and integrity of my research.

My final strategy involved making use of the social networking site *facebook.com*. I set up a Facebook page for my study, <https://www.facebook.com/EdinburghPregnancyStudy>, and used this to make contact with local pregnancy-related community groups in the hope that I would be able to post a link to my profile on their Facebook page. I contacted National Childbirth Trust groups within travelling distance of Edinburgh, and also a pregnancy and parenting group in Edinburgh. However, I received only two replies. One of these replies was from an Edinburgh branch of the National Childbirth Trust; the administrator of their website offered to post a link to my study website on their home page in December 2012, and this offer was gratefully accepted.

Three months after my data collection began, I had only heard from two participants. I remain unsure as to why the months of November to January yielded so few participants, but it could be due to women having less time (or interest) to check online message boards, or take part in my research, during the festive season. Because I was concerned about the time I had to conduct and analyse my interviews, I decided to add an element of opportunistic sampling (Ritchie et al., 2003) to the recruitment process. I did this by making use of a University of Edinburgh based

departmental mailing list which I had recently learned of, used by both academic and support staff to advertise items for sale and local events. I sent an email to this mailing list, with a link to my study website, in February 2013.

By providing women with a just a small amount of information on publically available message boards or in an email, and requiring participants to follow a link to further information and my contact details for themselves, I hoped that my methods of recruitment would be as unobtrusive as possible. This is in contrast to methods that would have involved personal contact with participants for recruitment purposes, such as approaching women in health centres. It was important to me that my participants were self-selecting, as I sought engaged respondents who would be willing to meet with me on more than one occasion. I was also mindful of the potentially sensitive subject of my research, and did not want to enlist participants who I felt had been coerced in any way (albeit unintentionally). I was especially aware of the possibility of distress that information about my study could cause, notably for those who had experienced miscarriage. However, by employing a strategy of self-selection, it is likely that I neglected certain experiences, particularly those of hard to reach groups including ethnic minorities and those from less affluent communities, whose voices are notably absent from qualitative research focusing on pregnancy (Coxon, 2014).

In total, the search for fifteen interviewees took place over a period of five months, from November 2012 to April 2013. Three were recruited as a result of the university mailing list, six through the link posted on the Edinburgh National Childbirth Trust Website, and six through online forums. My fifteen participants are introduced in an ‘Interlude’ section following this chapter.

3.6 Ethical considerations

Due to the close contact with participants necessitated by many forms of qualitative research, and the fact that its outcomes are not always anticipated, qualitative methods entail unique ethical considerations. This is particularly true of qualitative interviews, due to the fact that they are often in-depth and unstructured (Lewis,

2003). My own participants' wellbeing was a key concern before I had even met them, and engagement with ethical concerns began when formulating my research questions. On a practical level, these were enacted in my choice of study sample, decisions regarding timing and number of interviews, and in making sure participants were fully aware of what my research entailed.

As with all research, it was important that my participants, and potential participants, were informed of the aims of my research, what would be required of them if they agreed to take part, and what would happen to the data produced during interviews. This was relayed to participants in the form of an information leaflet (see Appendix V), which was emailed to participants as soon as they made contact with me. It was important that in the first email I made participants aware that participation in interviews was voluntary, and that they could leave the study at any time. This fact was also reiterated in the consent form I sent to participants along with the information sheet (see Appendix VI). I did not want my participants to feel obligated to attend subsequent interviews, and so used phrases such as 'if you are still happy to take part' when arranging second and third interviews. The information leaflet and consent form were emailed to participants at least five days in advance of our first interview, so that they could be discussed with participants' friends or family. The information sheet was read through again at the start of the first interview, with me on hand to answer any questions, and the consent form then initialled and signed.

The information leaflet also explained how I would ensure confidentiality and anonymity for participants; this included the omission of participants' names from transcripts and in reporting data. Though I needed to omit personal names, in line with my epistemological position I wanted to maintain a sense of the person when quoting and writing about my participants, so immediately gave each a pseudonym. I chose this by using the letter that corresponded with the numerical order in which I interviewed each participant⁵. I also made sure that the names of family, friends and specific locations were omitted from transcripts. Further, I made sure not to report

⁵ An exception to this was Sinead, who I interviewed before I decided upon this approach.

events which I believed could identify participants when presenting my results; for example, a specific and memorable encounter with a midwife.

Issues of anonymity and confidentiality also have implications for storing data. Recordings and transcripts saved on my personal office computer were identified by a number only, and the spread sheet I used to keep a note of information such as interview dates was protected by a password. All files were stored on a password-protected computer. Consent forms, which also featured participants' names, were stored in a locked cabinet. These were kept separately from transcripts and recordings, and my participants were informed of this procedure.

Though by providing as much information about the study as possible prior to the interview I ensured a degree of informed consent, I am aware that informed consent can never be fully achieved. This is in part due to the uncertainty inherent in qualitative interviewing, and the fact that participants are largely absent during data analysis (Mason, 2002). I tried as far as possible to renegotiate informed consent throughout the interviewing process, for example by asking each time we met whether my participant consented to having the digital recorder on, and sometimes discussing my initial analytic thoughts with participants following interviews. I also shared my interpretation of my interviewees' responses *during* interviews, to share these with my participants, and have them challenged if necessary.

The measures described above are common to many qualitative interview studies; however, my research topic required particular attention to protecting participants from harm. The most pertinent ethical consideration raised by my research design was the enrolment of participants, and discussion of their pregnancy, during the first twelve weeks (first trimester) of gestation. This raises particular issues for two reasons, which I shall address in turn.

Firstly, around 15% of pregnancies end in miscarriage, and of these the majority occur during the first trimester (Gabbe et al., 2012). I was mindful that an interview early in pregnancy, where discussion of a future baby had the potential to be raised,

may shape women's experiences of a subsequent miscarriage should this occur. Despite the fact that it was statistically possible at least one of my interviewees would experience a miscarriage, I argue that the possibility of miscarriage should not prevent qualitative research during the first trimester of pregnancy from taking place. Provided procedures are put in place to reduce the risk of further trauma following a miscarriage, and the possibility of breaching women's efforts to withhold the news of their pregnancy from family and friends, this should not prevent research considering women's understandings and feelings towards the foetus during the first trimester from being conducted. As demonstrated in Chapter Four, this period is characterised by silence in academia, despite the fact that such research has the potential to contribute to the improvement of the care women receive at this time.

To address this concern, before recruiting my participants I established a procedure whereby the participant or her family could send me an email or text message saying 'opt out', should they wish to withdraw from the study. I made each potential participant aware of this as soon as they contacted me. I also provided each participant with a stamped addressed envelope at the beginning of each interview; this had an assigned number written inside, so they simply had to place this in the post. I explained that if I received such an email, text message or the envelope, at any time, I would not contact the participant again. I also emphasised that they did not have to give a reason for their withdrawal. Due to the fact that interviewees were sharing their experiences of pregnancy with me, potentially without having informed wider family and friends that they were pregnant, I also had the numbers of miscarriage support groups on hand at each interview. Fortunately, a situation in which these would need to be provided did not arise during the research period.

The second important ethical consideration, related to the heightened chance of miscarriage during the first trimester, was that women often report keeping news of their pregnancy a secret from friends and family until they have reached the end of their first trimester, and in some cases beyond (Rothman, 1988; Ross, 2012). I was keen not to jeopardise attempts participants made to keep their pregnancy a secret, and this was especially salient when publicising my research. I decided that posters

would provide a memorable email address (pregnancy.study@ed.ac.uk), so participants could avoid the possibility of being seen writing it down. For the same reason, I did not provide tear-off slips listing my contact details. This concern was also attended to when selecting a choice of venue for the first interview. I made sure that I offered participants the option of meeting in a room on campus or in their own homes, thereby providing a space where they could not ‘bump into’ family or friends.

This offer necessitated an awareness of the potential risks to researchers when carrying out fieldwork (Lewis, 2003). I felt that the only situation that would pose a risk to myself would be meeting participants in their homes for the first time, or meeting participants in an area I was not familiar with. If I did meet participants at their homes, or in an unfamiliar location, I provided details of the location (though no names were used) to the department administrator. I then made contact on completion of the interview to let them know I was safe. This was only required on two occasions.

After having contemplated the ethical issues I thought I may face, and designing what I deemed were adequate measures to address them, my research design was granted approval by the University of Edinburgh Centre for Population Health Sciences Research Ethics Committee. I maintained an awareness that some concerns cannot be anticipated, and that I may have to make ethical and intellectual decisions ‘on the spot’ (Mason, 2002). I therefore continuously reflected on and sometimes modified my practice throughout my data collection to ensure ethical research. An example of this is my modification of topic guides, discussed below in section 3.7.2.

After receiving an email from a potential participant, I replied asking them to read an attached information sheet and consent form. I also suggested that, provided they were happy with the information, they email me with a suitable date and time for a first interview. This email was sent at least five days prior to a first meeting, allowing participants time to read over the study information sheet and consent form with family. This first email also outlined the ‘opt out’ procedure described above. I

informed participants that I would like to meet them once they had reached the tenth week of their pregnancy onwards⁶. For the most part, this gave participants over a week to read over the information sheet and consent form, and also decide to opt out of the study.

3.7 The interviews

My interviews, though conducted over a period of eleven months, involved a large amount of additional planning and preparation before they could begin. This, along with my account of the process of interviewing, is described below.

3.7.1 Using a longitudinal approach

As discussed above, based on my literature review it was important to me that I interview my participants on more than one occasion. This is because as well as significant changes to their bodies, existing literature has also suggested that women's feelings about the foetus change over the course of the pregnancy (Berryman and Windridge, 1996). Further, I was interested in examining women's engagement with the *various* technologies they encounter throughout pregnancy, due to the fact that much of the existing work in this area focuses solely on specific and discrete events such as the ultrasound scan. As discussed, based on my pilot work, I felt that these processes of change (but also continuity) would be best explored as they occurred, rather than through retrospective accounts. I therefore would be undertaking what may be termed longitudinal research, the definition of which is research "predicated on the investigation and interpretation of change over time and process in social contexts" (Holland et al., 2006: 1). Though the term 'longitudinal' is often applied to research taking place over many years (or even decades), according to Saldaña (2003) there is no consensus on the period over which a study may take place for it to be considered longitudinal. I am thus happy to refer to my research as longitudinal, due to the fact that in common with other longitudinal studies, my aim was to explore (changes in) a defined experience over a specific time-frame.

⁶ A reflection of how much the discourses of risk surrounding early pregnancy had also influenced my research practice.

As explained earlier in this chapter, and observed in Chapter Two, it was important that my first interview with each participant took place before their twelve week ultrasound scan (see Appendix VII for a timeline of interventions received during pregnancy). This was because existing literature claims the ultrasound scan is a key point at which women accept the reality of their pregnancy (Mitchell and Georges, 1998; Nash, 2007). I therefore wanted to explore whether the notion of a foetal subject, or related experiences such as the concept of a maternal-foetal bond, had any salience for women prior to this. However, it was important to me that I met participants as late as possible before the scan, in order that the chance of experiencing a miscarriage in the weeks following an interview would be reduced.

3.7.2 Topic guides

My first interviews with women focused on the pregnancy test, embodied knowledge of early pregnancy, telling others the news, and the eight week booking appointment (see Topic Guide 1, Appendix VIII). I found myself modifying the topic guides throughout the interviewing process. This was in response to ethical concerns, for example one of my participants had previously experienced recurrent miscarriages, but also because some of my questions intended for the first set of interviews, formulated in response to my literature review, did not make sense in relation to my participants' experiences. This related to questions probing an emotional 'connection' to the foetus. These questions did not make any sense to Sinead, my first interviewee, as outlined in Chapter One. As such I removed such questions my topic guides without ever using them. Due to the fact that miscarriage or as yet unknown foetal anomaly were a concern until my participants reached their twelfth week of pregnancy, I did not introduce discussion of a distinct entity (either foetus or baby) with participants, instead asking them questions such as "do you think about what is going on in there?". This remained a feature throughout all of my interviews, as I did not wish to influence participants' talk with regards the foetus. I managed this by reflecting back the terms used for the foetus by my participants.

My second interviews were planned to take place just before my participants' twenty week scan. This point in the pregnancy was decided based on interviews with my first two participants (Sinead and Andrea), who I interviewed four times in total to determine at which point I should conduct the second interview. I interviewed these two women at around thirteen weeks, and again at nineteen weeks in their second trimester. The interview at nineteen weeks proved most fruitful, as it was around this point at which both participants had begun to feel what they believed could be foetal movements. Due to a theoretical concern with the credence ascribed by women to various forms of knowledge of pregnancy, I decided that the experience of and uncertainty surrounding early foetal movement was something that should be captured in my interviews. I therefore decided to interview my participants for the second time at nineteen weeks, just before their twenty week scan. These interviews focused on the experience of the twelve week scan, any contact with midwives they had experienced, and their changing bodies (see Topic Guide 2, Appendix VIII).

The appointments scheduled for women in late pregnancy determined the point at which my third interviews took place. With the decline of routine technological intervention following the twenty week scan, I was interested in participants' responses to the manual foetal measurement and assessment carried out by midwives in the final weeks of pregnancy. Though guidelines state that this is carried out from the thirty sixth week of pregnancy (see Appendix I), I had learned from my pilot work that this may take place before the thirty sixth week. Eager not to lose participants due to an early birth, I therefore decided to carry out third interviews at thirty five weeks. These interviews focused on the experience of the twenty week scan (and finding out foetal sex if applicable), women's changing bodies, appointments with health professionals, and reflecting on their experience of the (almost) nine months of pregnancy as a whole (see Topic Guide 3, Appendix X).

My interviews with each participant therefore took place at around ten weeks, around nineteen weeks, and at around thirty-five weeks of pregnancy (with two extra interviews taking place with two participants at around thirteen weeks, described above).

3.7.3 *Doing qualitative interviews*

From the outset I had decided that I would only meet my participants in a face-to-face context, rejecting the idea of phone or Skype interviews. Though telephone interviews have been used successfully in qualitative research, and can yield an increased number of participants (Sturges and Hanrahan, 2004), I was concerned that I would not be able to build the rapport I wanted to with my interviewees. This was an important element of my research, due to the need to meet my participants on multiple occasions. Elements of rapport such as body language, and silent nods of understanding or agreement, encouraging elaboration, are unavoidably absent from telephone interviews. This is perhaps why one study found that face-to-face interviews lasted longer than telephone interviews, with telephone interviews also requiring the researcher to play a more dominant role (Irvine et al., 2010).

Accordingly, I felt face-to-face contact was also necessitated by my attempts to maintain a non-hierarchical approach to interviewing (Oakley, 1981), congruent with my methodological influences. In line with this approach, face-to-face interviewing was also more conducive to a reciprocal relationship, which I wanted to express by bringing a small gift such as a bunch of flowers if meeting participants in their homes, or purchasing a drink or snack for my participants when meeting in a café.

I had initially considered the use of props such as diaries in my research, however, following discussion with my supervisors, I decided against this. Anticipating that the experiences of gestation and the foetus would be fluid and changeable, I had originally planned the use of diaries for women to document any thoughts or dreams they had about their pregnancy or the foetus, and any bodily changes they noticed which could be overlooked in interviews where women were reliant on memory. Diaries can also help participants to explore aspects of their experience that they could find hard to articulate in an interview situation (Day and Thatcher, 2009). However, it was decided that completing diaries could provoke women to think about the foetus and their pregnancy more than they would without this intervention. This was ethically problematic, especially during the first trimester of pregnancy, when miscarriage rates are at their highest. Further, I also decided that I would not

want to further encroach on my participants' time; three interviews was a substantial commitment in itself for my interviewees, who were all working full- or part-time during my data collection.

I also considered asking participants to bring any artefacts of interest with them to the interviews, such as ultrasound images. Instead, I decided to observe whether participants already had such items in their possession (some authors note that ultrasound images are often regarded in the same way as 'baby pictures' (Mitchell, 2001; Han, 2009b)), or ask what had been done with them. This would help me to understand the status my participants accorded to such artefacts.

Though I suggested that participants choose a convenient venue to meet, and suggested possibilities including their home, a café, or on campus, nearly all of my interviews took place in cafés. This came as a surprise, as I had expected participants to want to meet in a private location during their first weeks of pregnancy, for reasons of secrecy described above. Only one participant asked to be interviewed at home, and I feel that our interviews benefitted from this. The home provided a space for my participant to speak without fear of being overheard, and perhaps levelled the power differential inherent in qualitative interviewing; I was a guest and therefore perhaps felt more nervous than she did on our first meeting. The quality of recording was also much better than those obtained in cafés, which were marred by customers' voices or noises from coffee machines. When meeting in cafés, I tried to arrive first to secure a table that was some distance away from other customers. This was to help protect my participants' confidentiality, allowing them to feel more comfortable. This was also of benefit to me, as I hoped this confidentiality would allow participants to feel more able to stray from socially determined norms of behaviour during pregnancy. I also tried to achieve this by making sure I, and not my interviewee, sat in the chair facing outwards towards the café and other customers. A final venue, used with two participants, was a room booked in my department at the University of Edinburgh. This related to participants wanting to maintain the secrecy surrounding their pregnancy; in both cases this was due to concerns about being 'found out' by their employer. These venues ensured confidentiality for participants,

however, I feel that my participants' lack of familiarity with these surroundings perhaps led to a degree of unease on their part, perhaps shifting the power dynamic too far in my favour (discussed below in Section 3.8). Further, these interviews felt less relaxed than others due to the more formal setting, which could have influenced how forthcoming my participants were in their responses.

As discussed above, having arranged a meeting place and time, the first interview encounter involved participants re-reading a hard copy of the information sheet I had sent them, with me on hand to answer any questions they had. After my participants had initialled and signed the consent form, I confirmed that they consented to the digital recorder being used before switching it on (I also re-confirmed this in subsequent interviews). Interviews involved me working through my topic guides, but omitting questions that had already been answered or which were not relevant to the participant I was with. For example, I had included a question about private ultrasound scans in my final topic guide, but only two participants experienced these. I therefore had to be prepared to adapt my questioning for each interview. By the end of my interview phase of research, I could largely work without my set of questions, though kept my topic guides in front of me at all times. As well as questions, however, my interviews also involved general 'chat' where there were pauses to the interview, for example to order food in cafés, but also my verbal interpretation of participants' answers. This involved me at times reflecting back what my participants had articulated, to ensure that my interpretation of what they had said was acceptable to them.

The strategies I used to establish rapport (discussed further in section 1.7), both deliberately and unintentionally, were for the most part successful, as all fifteen participants were willing to attend all three interviews over the course of their pregnancy⁷. My longitudinal approach was important to adequately attend to my research questions, but its use brought with it a unique set of methodological and ethical considerations, the most significant of which are described below.

⁷ One participant was unable to attend the third interview due to the early onset of her labour at 32 weeks

3.8 The researcher-participant relationship

During the course of my data collection, I began to interrogate the nuances of the research relationships I was entering into with my participants. I became conscious that this was an important aspect of interviewing during the composition of my ethical approval protocol and topic guides. It became apparent that I would need to more actively address the issue following a supervision meeting at the early stages of data collection. In my reflective diary I had noted that during an interview with one participant, who seemed quite anxious, I felt the need to reassure her on certain matters. For example, in response to a comment she made about eating more since she became pregnant, I commented that this was OK, as pregnancy is a time when women are “allowed to eat a bit more”. After discussion of the interaction with my supervisors, I realised that this was inappropriate in an interview situation. I am not clinically qualified, and as such am unable to give what could be perceived as health-related advice.

Following this incident, I became more aware of what I was saying to participants, and of how I said it. This also provided me with an increased sensitivity to how my participants spoke to me, and I began to realise that at times my participants’ tone of voice seemed to be *asking* for reassurance or affirmation, as is common in discussions between friends. An example that occurred twice in interviews was that the interviewee had inadvertently consumed a small amount of alcohol following conception, without realising they were pregnant. Telling their story and then reflecting on it seemed to provide participants with a way of reassuring themselves that everything was fine, and that no damage had been done to the foetus due to this small amount of alcohol consumption. However, after the earlier incident I discussed with my supervisors, I resolved that I should not agree with the rationalisations my interviewees made to reassure themselves; for example that lots of other women must have had a similar experience. I found this very difficult, as in a non-interview situation, my first reaction would have been to say ‘I’m sure you’ll be fine’.

A similar dilemma has been described by Oakley (Warburton and Oakley, 2013). When reflecting on her experiences of interviewing women experiencing pregnancy

and childbirth in the 1970s, Oakley explains that she was asked, and answered, many questions during interviews. She asserts that if researchers ask participants to talk about themselves and their experiences, they must be prepared for this to be an interaction, as opposed to a situation where the researcher is seen as a neutral questioner, and interviewee as passive respondent (Waburton and Oakley, 2013). This position was elaborated on in her discussion of a feminist mode of interviewing, where she berates what she describes as a masculine model of interviewing (Oakley, 1981). As discussed above, the non-hierarchical interview situation Oakley described has highly influenced my own approach to qualitative research. However, following my reflections on my role as a researcher and my responses to interviewees, I wondered if I had taken Oakley's approach too far, and resisted the features of the traditional interview so much that my interview interactions had begun to turn into interactions akin to those found in friendships.

The informal and egalitarian shape of my interviews perhaps owed to the fact that I shared a similar structural location to all of my interviewees; we shared the same sex, had been educated to a similar level, and were close in age. We met and talked informally in cafés, and I found it very easy to converse with most of my interviewees about this very personal topic. Our discussions often involved my interviewees recounting intimate changes to their bodies, and interactions with their partners. Finch (1984) attributes the ease with which women talk to female interviewers to their shared 'subordinate structural position', which enables a particular kind of identification. Some authors have therefore advocated emphasising similarity with interviewees, for example through self-disclosure (Song and Parker, 1995), in order to more easily establish rapport. I myself found that I emphasised my shared experience with participants during the interviewee, for example by empathising with concerns some interviewees had held about their age and fertility before becoming pregnant. I also motioned to different parts of my own body when asking questions about the bodily changes they were experiencing. However, in emphasising similarity and offering self-disclosure, there is the possibility that a research relationship may enter what Oakley calls a 'transition to friendship' (1981); this is especially salient when conducting repeat interviews. In the early stages of

interviewing I began to find it hard to maintain the boundaries between a research relationship and a friendship. For example on one occasion, when meeting a participant for a second time, we chatted about her work and colleagues before starting the interview, and as also experienced by Cotterill (1992), I found it difficult to know when to switch the tape recorder on and begin the interview proper.

Though it is important to recognise that all research is based around a relationship between the researcher and researched, and that positive rapport resulting from such a relationship may be hard to suppress (Stanley and Wise, 1993), I was also aware of the potential ethical issues which can ensue when the boundaries between interviewer-as-researcher and interviewer-as-friend become blurred. King and Horrocks (2010) describe rapport as the process of building trust, and allowing the participant to open up to one as an interviewer (2010: 48). However, Duncombe and Jessop (2002) highlight the potential for exploitation that establishing rapport, which they liken to 'faking friendship', can entail. This includes the potential to inadvertently influence participants' consent to take part in research, or encouraging participants to disclose and explore experiences or emotions which they may have wished to have kept private. My challenge as interviews progressed was therefore to allow my subjectivity into the research relationship, and embrace the positive aspects that my shared experience with interviewees brought to the interview process, while simultaneously maintaining the distinction between the researcher-researched relationship and a friendship. I thus made efforts to subtly reinforce my role of interviewer, as opposed to friend, as the interview process progressed. I attempted this by making sure I gave more neutral, though still positive reactions to cues for reassurance, for example by saying 'I hope so too'. I also tried to achieve this by switching the tape recorder on (after asking for consent) almost as soon as my interviewees arrived and leaving it on for as long as possible, and by having my questions in front of me for each interview, even when, in later interviews, I felt they were not needed.

Nevertheless, I found that some elements of a 'friendship' interaction were unavoidable. During my longer interviews for example, I would often verbally

introduce a pause from my questioning, to allow my participants to eat something, or for me to consult my topic guide. Such pauses felt like a 'break' from the interview and participants would often fill this, for example with questions about my PhD, or discussion of films. Following one interview, I wanted to help my participant by carrying a heavy bag, and so walked with her to her destination. Along the way, we browsed in shops together. This event raises questions about the ethics of only maintaining a 'researcher persona' during any and all contact with interviewees, and demonstrates the need to consider interview interactions beyond what takes place between the switching on and off of the tape recorder. I made sure to record these interactions, and how they may have influenced my findings, in my research diary.

My efforts to preserve the boundary between these two forms of interaction also influenced the ending of the research relationship. I felt I had built some form of connection with participants after meeting with them multiple times over the course of their pregnancy. This necessitated reflexivity with regards these relationships (Thomson and Holland, 2003: 242), and my reflections on such experiences were recorded in my research diary. Some of these issues have been described above. Though I was keen to be reassured of my participants' wellbeing following birth, in order not to force an extension of our research relationship, I suggested that they email me if they wished to, but made no arrangements to meet with participants on completion of my data collection⁸.

3.9 Analysis

Analysis of interview data was a continuous project throughout my research. As outlined above, this began during interviews themselves, with my verbal interpretation of participants' accounts. Following each interview I also made field notes in a designated research diary with regards the setting of the interview, and my initial interpretations of the key analytic matters to emerge from each encounter. In keeping with my methodological approach these were reflexive, and included an

⁸ Following our final interviews, I was contacted by all but two of my participants, who informed me that they had given birth to a healthy baby.

awareness of my role and influence on the interview, and reflections on its success (see Appendix XI for an example).

Following each interview, I transcribed the digital recording using Microsoft Word. Though it is common for researchers to outsource transcription, I found that the preparation of transcripts was central to my familiarity with my participants and their stories (especially salient for my longitudinal approach), and to the early development of analytic themes. Transcription is often a first step in data reduction, as decisions are made as to what will be transcribed and subsequently subjected to further analysis, and what will be left out (McLellan et al., 2003). For example, I decided not to transcribe the initial ‘catch up’ conversations that were caught on tape when seeing interviewees for the second or third time. I did, however, make sure to include where participants stressed particular words, or what I interpreted to be a sarcastic tone, as I saw these to be of analytic importance. Such language use could be demonstrating a particular emotion or criticism. I also had to make decisions regarding how often to re-listen to sections of the recording that I had at first labelled “[inaudible]” – an issue that recurred throughout the research process with the development of my analysis.

These judgements were also joined by wider theoretical interpretation. During transcription I often recalled literature resonating with my participants’ experiences, or noted commonalities between interviewees’ narratives. In these cases, I made use of the ‘footnote’ tool in Microsoft Word to make analytic memos. Following the creation of each transcript, these helped in the compilation of a single page summary of the interview. For me, transcription was thus a key phase of data analysis, and as such entailed its own requirements for reflexivity (Bird, 2005). Reflections in this regard were recorded in my research diary.

3.9.1 Using the Voice Centred Relational method

Following the completion of my interviews and transcription, I was keen to undertake a distinct and systematic stage of analysis. Though an interpretive approach is often seen as incommensurate with positivist criteria for judging the

integrity of research, such as ‘reliability’ or ‘validity’ (Altheide and Johnson, 1994), I intended to subject all of my data to the same process of analysis. This would contribute to my attempts to treat my participants’ accounts equally, and my efforts to consider all accounts in my analysis, even those ‘deviant’ cases that did not accord with the majority of my participants’ accounts. A rigorous approach to my analysis would ensure that I as closely as possible produced ‘plausible’ stories from my interview data (Melia, 1997). As discussed above, this approach complements a critical realist position. However, along with a stringent approach, I also required one that would grant flexibility and remain grounded in my interview transcripts, with the additional requirement of allowing for the longitudinal element of my research.

Turning to the literature, I become overwhelmed by the methods of analysis commonly described in qualitative methods textbooks (e.g. Green and Thorogood, 2004; Silverman, 2011; Creswell, 2013), and struggled to see how these would map onto my own research. As described above, several research paradigms informed my approach to this research, and as such I explored various frameworks for analysis including constructivist grounded theory (Charmaz, 2006), narrative analysis (Riessman, 2002) and thematic analysis (as outlined by Braun and Clarke, 2006). I felt that my research did not fit with the former two approaches, due to the fact that both entailed a specific protocol for data collection and analysis *from the outset*. At the start of my research, however, I was unsure as to what kind of accounts my interviews would generate, and as such did not shape my topic guides with, for example, a strictly narrative approach in mind. Further, longitudinal research raises specific concerns with regards when and how to commence analysis of the research, with new rounds of data having the potential to re-shape the researcher’s approach (Thomson and Holland, 2003).

The techniques of thematic analysis are often used in qualitative studies, though guidelines for a systematic approach were devised only recently (cf. Braun and Clarke, 2006). Having explored with this method, I felt thematic analysis seemed to be a sensible option for analysis of interviews cross-sectionally, and decided that this

would feature in my approach. It provides a means to organise data in terms of patterns, helping to describe but also identify key findings (*ibid*). However, I was not sure how it would be able to capture the longitudinal element of my research. I was also concerned that the emphasis on coding and fragmenting my participants' stories into 'themes', from the outset of analysis, would hinder my aim of interpreting women's experiences of pregnancy and various interventions in terms of their wider context. This included their relationships with others, and reproductive histories.

It was here I turned to Mauthner and Doucet's (1998) description of the voice centred relational method (VCR). Indeed, echoing my own frustrations, their paper laments the lack of detailed guidance on the practical elements of data analysis, and the exclusion of accounts of reflexivity from published accounts of qualitative research. Originally created within the discipline of feminist psychology (Brown and Gilligan, 1992), the method was reformulated by Mauthner and Doucet (1998) for sociological studies. The emphasis on the voice of the participant is maintained by conducting four readings of each transcript, whilst listening to the original recording, according to a 'listening guide'. This details a focus for each of the four readings: the story told by the participant (and the researcher's reaction to this), the way in which they talk about themselves, their relationships with others, and the situation of participants' accounts within broader social and political structures (Mauthner and Doucet, 1998: 125-132). Following these readings, the researcher produces a case study for each participant. This approach delays the reductionist aspects of other methods such as thematic analysis, helping ensure that the differences between respondents, as well as their similarities, remain in the researcher's consciousness throughout (Mauthner and Doucet, 1998: 134). Due to the emphasis on the voice of the participant remaining paramount, I felt this was best suited to my longitudinal approach, which over the course of data collection had resulted in fifteen rich and lengthy narratives.

I was further attracted to the method's explicit acknowledgement of the social context and relationships surrounding each participant, which from my pilot interviews I interpreted were an important influence on women's experiences of

pregnancy. I also appreciated its incorporation of researcher reflexivity into steps of analysis. Further, I felt that the development of a case study for my participants would enable their stories to remain intact for as long as possible, as opposed to their narratives being chopped up into codes or themes. Though of course I have fragmented my accounts in my presentation of results, I did not want to do this too quickly, to ensure I had familiarised myself as much as possible with my interviewees' accounts. It also was for this reason that I deliberately eschewed NVivo (a variety of CAQDAS). Though used during the analysis of my pilot focus groups, I found that the presentation of transcripts on a small computer screen, and the extrapolation of quotes from their wider context, was not conducive to the analysis of my longitudinal data. When analysing accounts produced during interviews, I had to consider experiences in relation to participants' narratives of events during each interview, but also in relation to two further encounters. In contrast to my pilot study, I therefore felt more comfortable conducting the analysis of my longitudinal interviews using paper copies of transcripts and coloured pens.

Having written out the listening guide outlined by Mauthner and Doucet (1998) for my own research (see Appendix XII), I began analysing my transcripts (in sets for each participant) according to the listening guide, in preparation for the development of a case study. However, after analysing my first interviewee, Sinead, I found that this needed to be adapted for my own research.

I appreciated the first reading, which outlined the participant's story, including the main protagonists and events. An important element of this was paying attention to *my* responses to the story told. Yet, whilst analysing Sinead's transcripts, I realised that the original listening guide did not explicitly account for participants' experiences of the foetus, an important aspect of my research. I replaced the second reading, focusing on how participants talked about the self, to account specifically for how women talked about the foetal entity. Further, I found it too time consuming to carry out four readings for each transcript, and so reduced this to three. I did this by combining the third and fourth readings, which looked for 'relationships', and

‘cultural and social contexts’ respectively. These were chosen because, based on the complex and detailed accounts she gave, I had found these difficult to separate in Sinead’s transcript. In a further change, I did not find it helpful to listen to the audio-recorded interview for *each* reading. I found that by listening, I was being led along by the recording as opposed to reading and concentrating on what participants said. As such I amended the method to only listen during the first reading. I used my new approach and framework (see Appendix XIII) with the rest of my participants. A summary of the steps I used is provided in Figure 1, overleaf.

Throughout all of my readings, I recorded issues of interest and reflexive observations in a designated analysis diary. In an example of my description of issues of interest, following my first reading of Heather’s second transcript I noted fluidities in her account, which were a common feature of my interviews:

Heather heard the heartbeat and said she felt ‘proud’, a pride she would feel for the rest of her life. This implies she is considering the future. BUT she also is hiding baby clothes she has received, because the baby has not arrived yet. Resonates with the concept of *two realities* (Gail’s term)

This later became a key theme in my research (see Chapter Four). My reflexive notes helped to ensure my analytical interpretations did not smother the voices of my participants. For example, following my first reading of Sinead’s first transcript, I wrote:

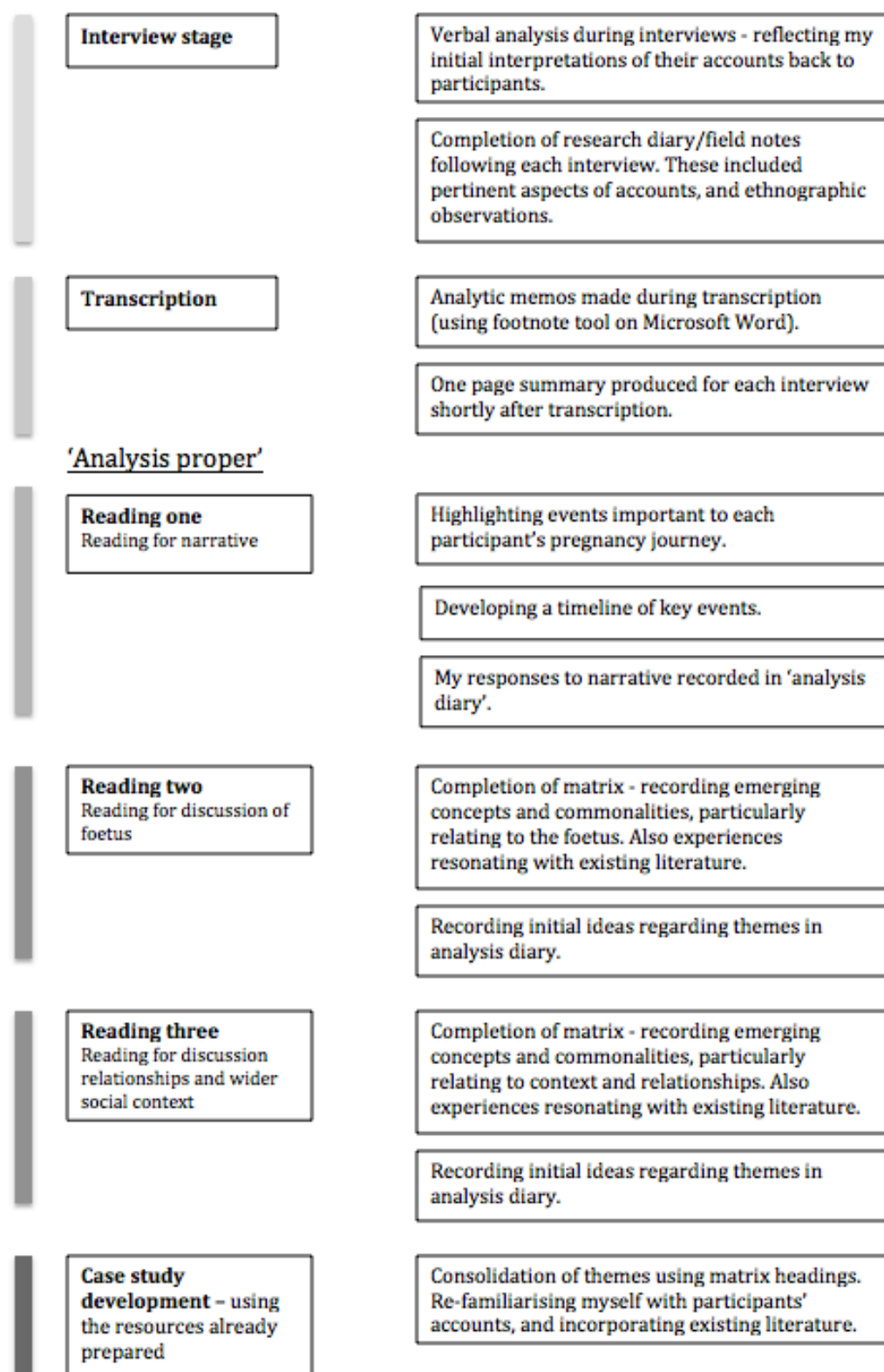
re: medical dominance – I point out when I am suspicious of medical treatment of women, i.e. in discussing the estimation of Sinead’s due date I said “they don’t trust you [to know your dates]”. BUT Sinead and others often challenged me when I criticised the medical profession.

This engagement altered the strength of the theoretical standpoint I brought to subsequent interviews, and the remainder of my analysis.

Though Mauthner and Doucet (1998) describe the ‘readings’ stage of their method extremely well, I was disappointed with the lack of detail in the explanation of their identification of themes and case study development. At this point I therefore

Figure 1.

Data Collection and Preparation



departed from their guidance, and drew on various resources which I thought best suited my research. Firstly, I developed timelines using flipchart paper during the first reading, to visually depict participants' narratives (see Appendix XIV for an example). This enabled me to become familiar with the key events and interventions described by interviewees. I was also able to note whether there were 'critical' experiences that coincided with particular events, both within and between participants' narratives. This helped me to reflect further on *my* reactions to my participants' stories.

It was during my second and third readings that I found it helpful to draw on some of the techniques used in thematic analysis. During this stage in particular, my participants' accounts were prompting many analytic and theoretical reflections. I created a 'matrix' for each of my three sets of interviews into which I could record these, along with relevant quotes or concepts used by participants. In the matrix I captured commonalities, ideas resonating with existing literature, and 'in vivo' codes (Charmaz, 2006: 55). The latter are terms used by respondents themselves that capture a specific concept – an example being Deborah's statement "I'd rather know" in relation to prenatal tests. This was a sentiment echoed by other participants, and appeared in all three matrices.

My approach thus used elements of both 'broad-brush' (more general categories) and detailed (looking for 'fine-grained' themes) coding (Bazeley and Jackson, 2013: 71). For example, one of the columns of from my first matrix was termed "pregnancy/birth as risky", but I also had a further column related to this named "tentative pregnancy". A sub-column relating to the 'tentative pregnancy' was called "preparing for the worst". I began to describe my use of matrices as 'backwards coding'. Though I was applying what may be termed 'codes' to their stories, this process was physically separated from my participants' transcripts, in order that they were not visually fragmented. The development of my matrix during my readings contributed to a coding frame, which I began to apply to later sets of transcripts, speeding up my analysis. I found these matrices to be invaluable in the writing stage of my research.

Using the many resources I had developed during my analysis, I then turned to the case study stage of the VCR method. I welcomed this as a way to ‘condense’ my audio recordings and vast pages of transcription into a manageable pool of data (Miles et al., 2014), whilst allowing for my participants’ narratives to remain intact for as long as possible. This entailed collating all of the resources I had created for each participant, including my field notes, timelines and interview summaries, and writing a substantial piece outlining their experiences of pregnancy and descriptions of the foetus, situating this into their wider context including relationships with others. Into this I incorporated relevant literature. This helped me further develop and collate the codes and themes identified during my second and third readings, for which I brought together literature and the experiences of other participants. Based on my initial stages of analysis, whereby time and milestones emerged as an important factor structuring women’s experiences of pregnancy, it felt natural to compose my case studies chronologically, rather than according to major themes. This approach has also been taken in the presentation of my results. My case studies also allowed for reflexive engagement with my analytical techniques. I was able to share these with my supervisors, who early on advised that I might have been ‘over-interpreting’, or what I described as ‘hijacking’, my participants’ experiences to accord with what I had taken from existing literature. For example, based on my knowledge of Rothman’s (1988) concept of the tentative pregnancy, in Gail’s case study I wrote:

I interpreted that she seemed to be concerned about the pregnancy, and as such felt that she was perhaps intentionally not attaching herself to the idea of a baby.

However, Gail never articulated such specific feelings herself, and as such it was problematic for me to infer as much as this from her narrative. I thus changed the style in which I composed my case studies, forcing myself to look at what my participants were saying, and not what I *thought* they were saying.

Due to the many stages involved, my analysis took a substantial amount of time, as also experienced by Mauthner and Doucet (1998). In total, analysis as a distinct stage, using my variant of the VCR method, took place over a period of ten months. Because of the time it took, towards the end the process overlapped with the writing up of my results. As such, using the method with my final few participants at times led me back to previous interviewees' narratives, as I had begun to forget their stories. In hindsight, this has strengthened my analysis – the movement back and forth between my transcripts and the writing process meant that analysis has been a continuous, iterative project. The stringent process of re-reading my transcripts in detail several times, along with the creation of various resources plotting the events and feelings described by my interviewees, certainly allowed me to “torture the data” (Glaser, 1992 in Melia, 1997: 32). This enabled me to become familiar with the stories of my participants, which has in turn aided the process of writing up my results, and contributed to methodological rigour.

This chapter has outlined the philosophical and theoretical approaches shaping my data collection and analysis. I have also highlighted the ethical issues inherent to qualitative research, but also the unique considerations necessitated by my longitudinal approach to data collection, and research relationships with interviewees. In line with my efforts to place my participants at the centre of my research, the following section represents a brief interlude to the thesis, where I present pen portraits of the fifteen women involved in my study.

Interlude

Fifteen women: my research participants

These brief descriptions of participants are intended to illustrate their diversity in terms of individual characters, but also in the events leading up to and surrounding their pregnancies. I have adapted these from the case studies made during my analysis. I present events that I have interpreted as particularly shaping my participants' individual experiences of pregnancy, but also aspects of their accounts that reflect their individuality.

Sinead, 25-29

Interviews at 11 weeks, 13 weeks, 19 weeks and 33 weeks pregnant

Sinead's pregnancy story began shortly after her marriage, around eighteen months prior to our first interview. Sinead and her husband had tried unsuccessfully to conceive for ten months, before seeking medical assistance. Sinead was diagnosed with a mild condition that inhibited ovulation, and after receiving treatment conceived within a few months. She experienced very bad morning sickness for the first twelve weeks or so, affecting her appetite and energy levels.

I conducted four interviews with Sinead, and during our later meetings noted her reluctance to let the pregnancy and future parenthood change her and her husband's identities. She expressed that she was afraid of becoming "just parents" rather than people in their own right and with their own lives. She linked this to her personality, which she described as not 'lovey dovey'. In our final two interviews she referred to friends whose lives had become consumed by their children; something she herself wished to resist.

Andrea, 30-34

Interviews at 9 weeks, 14 weeks, 20 weeks and 35 weeks pregnant

Andrea was unique among my participants in that she had experienced miscarriages prior to her current pregnancy. Her first two pregnancies had been lost before six weeks, with a third miscarriage being picked up at a twelve week scan. This last miscarriage had been particularly difficult for her and her husband, and resulted in her taking time off work.

Anxiety with regards to the safety of the pregnancy was a feature of all of our interviews, and was linked by Andrea to her reproductive history. This also influenced how she engaged with antenatal care. For example, she asked for the pregnancy not to be registered with her GP until she had had her first scan. Andrea also requested additional scans due to concerns she had about the foetus. Helping her through her anxiety, however, has been her Christian faith, which Andrea described as important to her connection to the pregnancy.

Beth, 35-39

Interviews at 11 weeks, 19 weeks and 34 weeks pregnant

Beth described her pregnancy as “not quite planned”, due to the fact that her and her partner had been together for only a short period of time before she became pregnant. However, Beth explained that having children was something that they had already discussed, linking this to the fact that she was over thirty five.

Beth described that her relationship with her partner had moved on quickly since becoming pregnant, and at the time of our first interview they were preparing to move in together. She often articulated her partner’s efforts to become involved in the pregnancy during our interviews. Beth also described how her social life was changing, as she had previously been known for enjoying nights out with friends. As

well as discussing her relationships during our interviews, the pregnancy was prompting her to rethink her career, which at the time involved a large amount of commuting. Looking to the future, she described wanting to spend this time with family instead.

Caroline, 35-39

Interviews at 8 weeks and 19 weeks pregnant

I met Caroline whilst she was eight weeks pregnant, the earliest point of gestation of all my participants. I was unable to conduct an interview at my preferred ten weeks, as she was due to travel abroad shortly after our first interview.

Caroline had planned her pregnancy, and conceived following a long relationship with her partner. She had sadly experienced a good deal of upheaval in the year prior to her pregnancy, following the death of a close family member. Related to this, she had been receiving pharmaceutical treatment for a mental health condition, though stopped this on learning of her pregnancy. Caroline expressed that she felt a responsibility for the pregnancy, and wanted to diligently follow medical advice with regards food and alcohol. In reference to this, she described herself as an “obedient” person.

Before our second interview, Caroline was admitted to hospital at seventeen weeks pregnant, which required a two night stay. There, medical staff prepared her for the fact that she may be experiencing a miscarriage. Caroline described this as a distressing event. Caroline reflected in our second interview that though she had enjoyed her pregnancy, she had felt anxious throughout. I was unable to meet Caroline for a third interview, as she went into premature labour shortly after we had scheduled a meeting. We later made contact and happily, she had given birth to a healthy baby.

Deborah, 35-39

Interviews at 12 weeks, 19 weeks and 35 weeks pregnant

Deborah was originally from the United States, and had become pregnant shortly after getting married. Indeed, she explained that her and her husband married “in order to have some kids”.

Deborah had initially found it difficult to accept the reality of the pregnancy. Partly owing to the fact that her and her husband had conceived within a month or so of their initial attempts, our first interview was characterised by the fact that Deborah felt she had no “proof” of her pregnancy, and as such it felt “abstract”. By our later interviews, her experiences had changed dramatically, as she began talking about the “baby” within her. I noted in my research diary that during our final meeting, I felt like her baby was already present during our interview. Interviews were also characterised by frequent discussion of her husband, for example with regards his feelings, or his efforts to become more involved with the pregnancy.

Eve, 25-29

Interviews at 9 weeks, 19 weeks and 35 weeks pregnant

Eve had been anticipating a pregnancy following her marriage, but first wanted to become familiar with her natural fertility. She therefore stopped using oral contraceptives for around a year before beginning to try for a baby.

Originally from the United States, the subject of family was an important aspect of our interviews. Eve regularly kept her family informed of the pregnancy’s progress using Skype, and family relationships featured heavily in her account of her pregnancy. She connected these relationships to her engagement with advice regarding caffeine and alcohol. She found these difficult to abstain from due to their role in rituals, such as long morning chats over a coffee, shared with her husband and wider family. She also described the role played by her young cousins in enabling

her to think of the foetus within her as a baby, a result of them having assigned it a name.

Eve said that taking part in this research made her think more about the processes of pregnancy (Heather also articulated this). She said that answering my questions had made her feel more connected to the pregnancy, due to the fact that she had been required to reflect on earlier stages that she would perhaps otherwise have forgotten.

Felicity, 25-29

Interviews at 10 weeks, 19 weeks and 35 weeks pregnant

Felicity explained that she and her husband had always planned to have children, and that for the last two years in particular she had been feeling “broody”. She had become pregnant after around six months of attempting to conceive. She reflected on the ways that her work in the life sciences may have influenced her experience of pregnancy, for example she was used to seeing ultrasound images of (non-human) foetuses. Indeed, she did discuss the role played by hormones more than other participants (as did Julia).

Like Caroline, Felicity visited the hospital at around eighteen weeks due to symptoms associated with a pregnancy loss. After having had the foetal heart rate monitored however, and a scan, no issues for concern were detected. Because the sex of the foetus could not be determined at her twenty week scan, Felicity later enrolled in a study offering further imaging of the foetus and placenta, in order to find out this information.

Gail, 35-39

Interviews at 10 weeks, 19 weeks and 35 weeks pregnant

Gail had become pregnant two years after getting married, deciding with her husband that “they couldn’t really put it off any longer”. This she explained with reference to her and her husband’s age. A keen traveller and cyclist, she also described that their decision to become pregnant came at a time when they had no excursions planned.

Gail was self-employed, and this influenced the announcement of her pregnancy. She described that the fact she worked for multiple employers made telling others complicated, and that she was concerned that various contracts would not be extended. Gail was therefore trying to work on rearranging existing commitments to fit with her pregnancy and maternity leave. Characterising my interviews with Gail was her questioning of certain pieces of medical advice she received. She asserted that she was adding her own judgement and “common sense” to the information she had read. Gail was keen to ride her bike for as long as possible, though this is advised against in the NHS guidance after six months gestation. When we met at thirty five weeks she was still cycling, though for shorter distances, and rarely for leisure purposes.

Heather, 30-34

Interviews at 11 weeks, 20 weeks and 35 weeks pregnant

Heather had become pregnant after travelling the world with her husband, and had ceased taking her oral contraceptive for eight weeks before conceiving.

During our interviews Heather often reflected on the changes that the pregnancy and a future baby would bring to her life, including to her career and relationship with her husband. She noted in our second meeting that she felt she was changing from an active and “tom boy” type of person to more of a “home bird”. As well as being linked to what she called “nesting” (preparing the home for the future baby), this was

also due to a desire to protect the pregnancy from harm. She was looking forward to the new challenges that having a baby would bring, and the chance this would provide to learn more about herself, and for her and her husband to learn more about each other.

Ingrid, 30-34

Interviews at 12 weeks, 18 weeks and 35 weeks pregnant

Ingrid, originally from a region of North Africa, had been educated in the UK, and was working full-time when we first met (she left her job towards the end of the pregnancy). Before becoming pregnant, Ingrid regularly attended the gym, which she described was an important aspect of her life. She was eager to continue this throughout the pregnancy, though had already begun to adapt her routines. Perhaps owing to this, she explained that she was extremely aware of her body. As such, Ingrid described that she could tell the pregnancy was progressing due to the bodily changes she was experiencing, which were very obvious to her.

Unlike other participants, Ingrid had been a smoker, but said that she stopped immediately on finding out that she was pregnant, due to the harm it could cause to her “child”. She was extremely excited about seeing the foetus on the scan, and in the first interview had begun looking to the future in terms of the future baby’s appearance, its sex, and names. She was one of two participants to purchase a private scan later in pregnancy, as she was eager to find out what the foetus looked like. Ingrid described that she already felt love for the “baby” during our last interview.

Julia, 25-29

Interviews at 10 weeks, 19 weeks and 35 weeks pregnant

Julia moved to the UK to begin a postgraduate degree. Her pregnancy was planned, and she conceived within two months of her and her fiancé beginning to try for a baby.

Julia drew on her background in the biological sciences throughout our three interviews, for example in her description of the pregnancy test as a ‘scientific assay’ (influencing her straightforward acceptance of the result). She also cross-referenced the advice she received with academic research and publications. She regularly engaged with online forums throughout gestation, finding them useful to ask questions, but also to network with other women experiencing pregnancy.

Keira, 30-34

Interviews at 12, 19 and 35 weeks pregnant

Keira and her husband had been married for over a year before our first interview. After travelling the world, starting new jobs, and then waiting until “things settled down”, they began to start trying for a family. Keira explained that she then became pregnant very quickly.

Keira often described feeling responsible for the pregnancy, and articulated experiences of feeling “judged”. She explained that she felt “guilty” after eating some sweets in the days before our first interview, and also how she was made to feel guilty by her midwife, after drinking a small glass of wine. This she linked to the mixed messages received from medical sources, not only with regards alcohol but also other foods to avoid. Keira described feeling confused, and also overloaded with information during pregnancy. This dissipated as the pregnancy progressed, though Keira’s sense of responsibility for the foetus was articulated throughout our interviews.

Leila, 30-34

Interviews at 11 weeks, 19 weeks and 35 weeks pregnant

Leila contacted me very early in her pregnancy, when a positive test showed that she was one to two weeks pregnant. As discourses of risk regarding miscarriage had influenced my approach to my research, as well as my participants' approaches to their pregnancies, I postponed our interview until she had reached a later point in gestation. Leila had been married for around five years when we met for our first interview, and she described that both her and her husband's families had been speculating about a future pregnancy. Leila became pregnant after around nine months of trying to conceive.

I noted that throughout our interviews Leila would voice her apprehensions with regards the role played by friends and family members in her pregnancy. She was concerned that their judgements and expectations would prevent her from being pregnant and bringing up a child, including her decisions with regards breastfeeding, in her "own way". She was therefore keen to keep aspects of the pregnancy, including knowledge of foetal sex, between her and her husband for as long as possible.

Marisa, 35-39

Interviews at 9 weeks, 19 weeks and 35 weeks pregnant

Marisa worked full-time in a job involving outdoor visits, and had been married for almost a year prior to our first interview. The pregnancy was planned, and Marisa conceived soon after they began trying for a baby.

Marisa described feeling more nurturing towards other people's children since becoming pregnant. She was eager, however, not to make too much of a "big deal" of the pregnancy, and made sure that when with friends she talked about topics other

than her pregnancy. She noticed that her social life had ‘calmed down’ since becoming pregnant. By the time we met for our second interview she was meeting friends for lunch, as opposed to in the evenings, as she had in pre-pregnancy. When we met for the final time, changes to her body had meant that Marisa had had to change her routines at work. She was no longer able to walk long distances and climb over obstacles, and as such she had to stop site visits at work.

Nancy, 25-29

Interviews at 11 weeks, 19 weeks and 33 weeks pregnant

Nancy had been with her partner for around four years prior to our first meeting. They had recently married, and Nancy explained that “very quickly” they began talking about having a baby. Indeed, Nancy said that at the back of her mind she and her husband knew that they were getting married in order to have children.

Though she had not experienced previous pregnancy losses, Nancy initially (particularly during our first interview) described her anxiety with regards the pregnancy in a similar way to Andrea. Contributing to this was an incident she experienced the day after her twelve week scan, where she experienced extremely heavy bleeding. She went to hospital, expecting to be told she was miscarrying, however, a scan showed that the foetus was healthy. Nancy continued to experience bleeding for the following two weeks, which was attributed by health professionals to the position of the placenta.

Later in gestation, the pregnancy began to cause Nancy extreme pelvic and back pain. This was to the extent that when we met for our last interview, she was using a crutch, and was unable to climb stairs in her home.

Chapter Four

The tentative (early) pregnancy

4.1 Introduction

This chapter explores my research participants' experiences of the first twelve weeks of gestation. I found that these resonated heavily with Rothman's (1988) concept of the 'tentative pregnancy'. During this time, my interviewees voiced feelings of uncertainty, and a reluctance to think too positively about the pregnancy. Their experiences in this regard were linked to their understanding that this period entailed the highest risk of miscarriage. This interpretation was due to multiple factors, explored throughout this chapter. I will also consider how early pregnancy was experienced as ambiguous for participants, and entailed the balancing of 'two realities' – one in which they were pregnant, and one in which they remained non-pregnant women. A significant element of experiences of pregnancy as tentative and ambiguous was the emotion work undertaken by my participants to manage these positions. I shall demonstrate the strategies used by women in this regard, including their adherence to what I have termed the 'twelve week rule': the maintenance of secrecy with regards their pregnancy for the first trimester.

I will foreground this discussion of early pregnancy with an exploration of participants' experiences of conception, which were also characterised by uncertainty. Their hesitancy to assume that they would conceive easily, and also their reluctance to accept the result of an initial positive pregnancy test, further resonate with the notion of the tentative pregnancy. I hope to show that this concept, originally formulated to describe encounters with prenatal diagnostic technologies, has relevance beyond these events, and may enhance understanding of women's experiences during the first trimester of pregnancy more generally.

4.2 The tentative conception

In what follows, I present women's experiences of conception, incorporating their accounts of becoming pregnant, as well as their experiences of the home pregnancy test. These paralleled the tentativeness of early pregnancy, considered in the latter part of this chapter.

4.2.1 "These things don't happen quickly"

For the majority of my participants, all of whom had planned their pregnancies, the uncertainty characteristic of early pregnancy seemed also to be a feature of their journey to conception. Reflecting on their experiences, most of the women I spoke with had forecast that it would take them a long time to become pregnant. Their explanations for this drew on the experiences of friends and family, including those who had undergone fertility treatment, and/or statistics they had obtained from medical professionals or the Internet. For example, Deborah explained that she had prepared herself for the possibility that conception may take many months:

All my friends like, a lot of them, took 20 months, 18 months, 6 months, or they haven't been able to conceive and they've had IVF, you know, and so I just had really low expectations.

Deborah, 35-39, 12 weeks pregnant

Though presented with favourable evidence with regards her chance of conceiving within six months, Heather was also mindful of the possibility that this was not guaranteed:

I think um, the information that you get from GPs, at the moment says something like, 60 percent of people will conceive within six months...I'd say quite a lot of my friends have probably conceived within about 6 months, but my brother has had a lot of problems and is having IVF, so, I guess I kind of parked myself somewhere in between...I'm not one to kind of, count my chickens, as it were.

Heather, 30-34, 11 weeks pregnant

Heather's estimates for conception seemed to be influenced by her brother's difficult experience, as opposed to the more positive outlook obtained from medical sources

and the experiences of friends (earlier in the interview she explained that she thought conception could take two years). Like Heather's stance, whereby she did not "count her chickens", other participants similarly explained that they did not make any presumptions with regards a successful conception, with Keira explaining that "I thought in my head that maybe it'll take a while", and Beth asserting "these things don't happen quickly".

Interviewees thus adopted a hesitant outlook with regards a successful conception. These experiences accord with those of the participants in Locke and Budds' (2013) research, which considered women's decisions regarding the timing of their pregnancies. Women in this study articulated a sense of risk regarding infertility or difficulty conceiving, where "expected poorer fertility was treated as the norm" (Locke and Budds, 2013: 533). Participants invoked anecdotes of friends who had taken many months to conceive, and, due to the length of time it may take, articulated a sense of needing to start trying for a baby as soon as possible. These sentiments were similar to those of my respondents, despite the fact that all of those interviewed by Locke and Budds were over thirty five, an age often presented as a threshold after which the likelihood of infertility increases (e.g. Maheshwari et al., 2008). However, whilst Locke and Budds describe their participants' experiences in terms of risk and its avoidance, i.e. by needing to have children as soon as possible, the concept of 'tentativeness' better describes the narratives given by my interviewees, who did not discuss notions of threat with regards infertility. Instead they articulated a sense of 'preparing for the worst' with regards the *ease* with which they would be able to conceive. This phenomenon seems to contrast with the emotional outlook generally encouraged for matters of health, which is to 'think positively', and remain 'hopeful' (del Vecchio Good et al., 1990; Wilkinson and Kitzinger, 2000), in a sociocultural context where the maintenance of good health is understood to be a moral duty and matter of individual responsibility (Petersen and Lupton, 1996). I suggest that though a seemingly contrasting approach, the measures taken by my participants nevertheless represent similar strategies of emotion management. However, instead of adopting an optimistic view, participants prepared themselves should the desired outcome (in this case an uncomplicated conception),

not be realised. This was also a feature of their experiences of early pregnancy (described in Section 4.3.2).

In line with this outlook, the women I interviewed described that conception was something that would need to be worked at to succeed, and would not occur by having unprotected sex alone. Many thus distinguished between ‘trying’ and ‘not trying’ to get pregnant. ‘Trying’ entailed the use of ovulation tests or mobile phone applications providing fertility calendars. Despite the planned use of these resources by some, the majority of my participants became pregnant within two or three months, and were surprised that this had occurred so quickly, and without the need to ‘try’. For example, Julia and Caroline explained:

We didn't really try, it wasn't like we were actually looking at like ovulation, we just, had sex.

Julia, 25-29, 10 weeks pregnant

We hadn't been using contraception for a while, not that we were really trying hard to conceive.

Caroline, 35-39, 8 weeks pregnant

Deborah, 35, explained that she had been prepared for conception to take around a year due to her age. She had begun to monitor her cycle, and was planning to take her temperature every morning and closely monitor her fertile days during attempts to conceive, recording information on a fertility chart. Exemplifying her low expectations with regards conception, she explained that should she not get pregnant within three to six months, she would be able to seek medical assistance, having tried to conceive at the optimum times (a strategy also planned by Marisa). Ultimately, Deborah became pregnant very quickly, and on her and her husband's first attempt at conception, which shocked them both:

I told my husband, I said 'I think I'm pregnant', and he was like 'no you're not, there's no way', cos we didn't even like, I didn't even have dates planned, you know like I, I was gonna be very scientific starting in January we were like, with looking at ovulation and all of that kind of stuff, we, I didn't, at all.

Deborah, 35-39, 12 weeks pregnant

She described feeling like she had “cheated the system” because of the ease with which they conceived. Those of my interviewees who did conceive within two or three months also felt that this was ‘lucky’. For Gail, this contributed to a sense of the unreality of the pregnancy:

There was no period of like, trying and wishing for it or anything like that, it was just, instant, which means it feels a bit like, it's kind of, not real or too easy or, something.

Gail, 35-39, 10 weeks pregnant

Not all, however, approached conception with low expectations. Two participants, Felicity and Leila, had taken six and nine months to conceive respectively. They seemed unprepared for the length time it took them to conceive. For Leila, like Heather above, her initial expectations for the time it would take were based on the experience of her sibling, a sister who she described as “super fertile”. Though discourses of infertility shaped some of my participants’ experiences of conception, these were thus interpreted in line with their personal experiences: for example how long they had been taking oral contraception, and the conception stories of friends and family. Yet, for a minority of women in my study these experiences could also supersede concerns regarding their ability to conceive, or concerns may not have been present at all. This was demonstrated by Ingrid, who, compared to other participants, modestly described trying, and succeeding, to conceive;

I just turned thirty actually, in July, and I thought, it's about time I had a baby, we just tried and I got pregnant, and I found out and I was just excited and that was it.

Ingrid, 30-34, 12 weeks pregnant

However, though she did not articulate the concern felt by others regarding her ability to become pregnant, age was nevertheless a consideration, influencing the timing of Ingrid’s pregnancy.

We have seen that discourses regarding the potential difficulty to conceive loomed large in the majority of my participants’ narratives, even for those under 35, having important consequences for the personal lives and decision-making of my

participants. This approach to conception, characterised by uncertainty, and an avoidance of thinking too positively, was also a feature of some participants' experiences with home pregnancy tests.

4.2.2 Testing for a pregnancy

Though all of my participants took at least one pregnancy test, the experience of these tests, and also the circumstances prompting their use, were markedly different. In the discussion that follows, I show how the pregnancy test, a seemingly one-dimensional technology, is in fact highly flexible: interpreted, used and made meaningful in multiple ways (Pinch and Bijker, 1984). My participants' uses of the test also reflect the hesitancy with which they had approached conception: for the majority, one positive test alone was not sufficient to confirm a pregnancy. Nine participants re-took a pregnancy test following an initial positive result. This was partly because a positive reading was not always interpreted as such, but also due to participants' need to 'double check' the result.

4.2.2.2 Suspecting a pregnancy

During my research, I heard many different accounts of the events leading up to a pregnancy test. Five participants cited a missed period as the reason for taking a test. However, this more obvious symptom of pregnancy was not as common a reason for testing as participants' descriptions of other changes in their bodies, which could less conclusively be linked to a pregnancy. For some participants, these were inexplicable, and many found them hard to describe. For example, Keira tried to articulate a sense of a change in her body by drawing on the notion of an "energy":

I kept like, imagining or thinking like I had this sort of energy in my tummy, which was really weird because I think it might just have been kind of the excitement of knowing it might happen, or it could have been something else but, so there was that, that was the only little thing that made me feel a bit different.

Keira, 30-34, 12 weeks pregnant

Beth, Nancy and Leila were similarly unable to fully explain what led them to believe they were pregnant:

It was ever so strange cos I'm not a very superstitious person at all, but, um something, I was due my period on the Friday, and it was the Tuesday, and something in my head just said 'take a test'. And I don't know why, cos I knew that, I could have waited 'til the end of the week, to see if my period came or not, and um, yeah, I just thought 'oh no I need to take a test'.

Leila, 30-34, 11 weeks pregnant

I just felt like there was something going on, I don't know how to explain it, just I felt there was something odd and different feeling about my lower stomach basically.

Nancy, 25-29, 11 weeks pregnant

Ingrid however, drew on both an inexplicable sense of change, but also a more measurable sign of pregnancy, knowledge of which she had gained from non-medical sources:

When I was around three weeks or something I knew...I could tell, my pulse was very, faster. I saw that in a movie, and then I looked it up, and I remember my grandmother telling me that that happened, you feel the pulse in your neck gets a bit faster when you're pregnant. And I felt it. I could feel that my pulse was fast...I just felt different, something about me, and I thought, I actually am pregnant.

Ingrid, 30-34, 12 weeks pregnant

Despite its potential importance for the timing of antenatal care and targeting of health promotion to encourage healthy pregnancies, as well as timing of abortion, little research has discussed women's ability to recognise signs of a pregnancy. Indeed, self-diagnosis of a pregnancy based on embodied knowledge is often not considered to provide sufficient proof of a pregnancy. Jordan, writing in the 1970s, suggests that this is due to a prevailing view that pregnancy diagnosis is a medical task (1977: 10). The now wide availability of the home pregnancy test has arguably provided women with more control over their pregnancies and their bodies, as they are able to conduct a test earlier, and in the privacy of their own homes (Leavitt, 2006). However, it is important to note that 'proof' of a pregnancy remains dependent on a medico-technological assessment of a chemical substance by the pregnancy test, rather than on women's embodied knowledge. That a woman will

take a test to determine whether she is pregnant is expected by both medical professionals (Layne, 2009), and the women I interviewed.

Perhaps a reason for a lack of emphasis on women's embodied experience in diagnosing a pregnancy is that there is an inconsistency between when a woman may begin to experience symptoms, and when a pregnancy test can detect the hormones indicative of an early pregnancy. The limits of the technology meant that for some participants, the results of a pregnancy test did not accord with their embodied experience. My interviewees responded to this in varying ways.

4.2.2.3 Taking the test(s)

Home pregnancy tests detect the hormone human chorionic gonadotrophin (hCG) in urine. This hormone is released by the fertilised egg, and facilitates the secretion of progesterone during the first trimester (Devaseelan et al., 2010). However, hCG changes in nature as a pregnancy progresses, and tests purchased over-the-counter are unable to detect the variant of hCG produced during the earliest weeks of pregnancy (Cole, 2009; Haarbarger and Pillay, 2011). As such, testing is recommended from the first day of a missed period, at which time the result is often cited to be 99% accurate (Cole et al., 2004). The maximum time advertised for diagnosis before this is five days before a period is due, providing 62% accuracy (Church and Dwight UK Ltd, 2014)⁹. Women may therefore experience embodied signs of pregnancy, for example those caused by hormonal changes soon after conceiving, but be unable to gain a quantitative assessment of whether or not they are pregnant. This was the case for seven of my participants, and prompted some to take a test before their period was due. For three participants, these initial early tests gave a negative result. Beth for example, had “subconsciously” felt that she was pregnant, and therefore tested early:

Beth: The week before my period was actually due, I said to [my partner] I'm not, I'm not feeling ill but I'm feeling a bit, I just said to him I have a feeling I might be pregnant, he goes, no, you can't be...I did a test, and it was

⁹ Clearblue digital tests, more common amongst my participants, advertise 4 days before a period is due, though these present a result with 55% accuracy

negative. And uh, he said well there you are, and I said no, I'm feeling, feeling like my period's coming, but it was different...I kind of thought 'I am', I have to be, I know how I feel, it's different. But I couldn't quite put my finger on what it was.

Emily: So when you, when you got the negative one, what did you think?

Beth: That's not right [laughs]. I was disappointed, I felt disappointed, but it was like, um, no that's not right.

Beth, 35-39, 11 weeks pregnant

We see here that Beth privileged her embodied experience over the results of the pregnancy test. She was adamant that the test was incorrect, and therefore took another test the following day, which gave a very faint line indicating a pregnancy. Deborah also noticed symptoms early in her pregnancy, but unlike Beth, accorded more authority to the *test* than her embodied experience:

*I just didn't know what could possibly be wrong with me...it was either like the day after we conceived, or within 5 days, like 5 or 7 days. So it was like instantly I felt totally off... I just knew it, I just knew it... I did three times and they were all negative... **I still felt funny, but I just thought, it's, no, the test said it's wrong**...then I went to this meeting, and I had like 1 glass of wine...then um, I was, it was Christmas morning, and I just thought, you know what, I'm gonna go, and have a big family piss up, and I just, I should try, I still hadn't had my period. So I took it and it was positive.*

Deborah, 35-39, 12 weeks pregnant. Emphasis added.

Deborah later explained that the negative tests had made her feel that she was “going crazy” and “imagining symptoms”, so strong was her conviction that the initial, negative, test results were correct.

Caroline similarly seemed to accord authority to the pregnancy test (though as we shall see below, her engagement with the test was not this straightforward). She began trying to conceive shortly before Christmas, and took some pregnancy tests with her when visiting family. She described feeling more tired than usual prior to taking a test, but was confused about whether this was caused by a pregnancy. Like Deborah, the reason prompting her test was to check whether she was able to drink alcohol. However, after taking several tests described as “cheap ones from Tesco”, she initially received negative results. Her experience demonstrates that the inability

of over-the-counter tests to detect a pregnancy during its early stages may cause anxiety for women with regards foetal health:

*I didn't get the, real positive one until...around the second of January, and that was, and then I did one of the ones **that was, not a cheap one**, [laughs] one of the Clearblue ones that tells you how long you, since you conceived um, **and that was, much more, definite**, and I said right, and it said 'one to two weeks' on that one so, it was quite early. So, but then there's, of course had a massive panic about, all the things that I'd done, drinking and everything over Christmas, so I was kind of worried about that*
Caroline, 35-39, 8 weeks pregnant. Emphasis added.

Here, as well as according primacy to technology over other forms of knowledge of a pregnancy, such as her tiredness, Caroline also subtly ranks the two types of pregnancy test she used according to their reliability; juxtaposing the 'cheap' Tesco ones with the 'definite' result provided by the Clearblue (digital) pregnancy test. This was common to many of my participants, who used a variety of forms of pregnancy test. On the whole, a hierarchy existed in the perceived reliability of tests. Below I present the different forms of test discussed by my participants, in order of their perceived quality:

- **Cardboard strip tests** are thin pieces of cardboard which when dipped in a urine sample will display a control line, and a second line if a pregnancy is detected. The strength of the line will vary with the amount of hormone detected. They can be obtained cheaply on the Internet, and come in multipacks of up to 50. These were used by just three of my participants.
- **Midstream tests** were the most common test discussed by participants. These are readily available at supermarkets and chemists, and are designed to collect a sample from a urine stream. These tests have a plastic casing, and again display a control line, with a second line in the event of a pregnancy. Like cardboard tests, the strength of the line will vary according to the amount of hormone detected. These tests are available to purchase as single units, or as a two- or three-pack.

- **Digital midstream tests** are similar in appearance to conventional midstream pregnancy tests. What sets this test apart from others is the way the result is displayed. A small digital screen either shows ‘Not Pregnant’ or ‘Pregnant’; there is no variation according to the amount of hormone present. If pregnant, an estimate of the number of weeks passed since conception will also appear. These are the most expensive pregnancy test, and can be bought as single units, or in packs of two.

All of the participants who used the digital test saw this as more trustworthy or reliable than other forms that they had tried. The digital test was used by seven of my participants, and it was most frequently employed after they had first used one or more non-digital midstream pregnancy tests, in order to *confirm* a positive result. Three participants used the digital test to clarify an uncertain result. As the strength of the line varied according to the amount of hormone present in other forms of test, the result could be uncertain if very faint. Users therefore often supplemented their reading of non-digital tests by ‘Googling’ images of positive pregnancy tests, consulting with their partners, and of course taking additional tests:

I got some more tests, cos by that time my period was a few days late...it came back with a very, very faint line...I spoke to my partner and he was like ‘yeah that’s definitely a line’, and then I took some more, and then there was nothing on those...I don’t think I really believed that, it was, that was telling me truthfully that I wasn’t pregnant. I think I sort of felt, like, I think, no by that time I’d probably done tonnes of googling, about it, and like ‘what happens if you get a really faint line on a pregnancy test’, and read tonnes of stuff on forums and things like that.

Caroline, 35-39, 8 weeks pregnant

I think I had a spare one, it was like a cheapo Tesco one I didn’t trust, so I kind of just kept that anyway, I dunno why I kept it, and I had a couple of other ones that were a bit better, I tried that but the line was so, so faint that I didn’t quite believe it. So, and then I went and bought one of the really posh digital ones, and that was ‘yay, pregnant’, one to two weeks.

Leila, 30-34, 11 weeks pregnant

We see then that taking a pregnancy test involved more than the passive acceptance of a visual result. Understandings of the test as simply a scientific assay (as described

by Julia), producing an objective assessment of whether one is pregnant, ignore the work undertaken by the user to produce a result (Childerhose and MacDonald, 2013). This includes the selection of days on which to test and deciphering their corresponding levels of accuracy, and the comprehension of the ‘rules’ of the pregnancy test; for example, manufacturers often advise use with the first morning’s urine due to the greater concentration of hCG present. Finally, there may be a great deal of interpretation, and consultation with others, before the user settles upon a result. The presence or absence of a line, indicating a pregnancy, is therefore a collaborative endeavour. It seems that the digital test was favoured due to the *minimal* interpretation required, along with its provision of an estimation of time since conception, adding to the certainty of the positive result. As Beth described:

It spells it out for you. It says, you know, pregnant one to two weeks. You see it in black and white...it’s not just you’re trying to go ‘is there a line there?’
Beth, 35-39, 11 weeks pregnant

This also accords with existing research exploring women’s use of home pregnancy tests. Digital tests proved to be the most easy to use and interpret (Pike et al., 2013), and provided the most certain result for women (Tomlinson et al., 2008). However, the very nature of the technology *in itself* seemed to be favoured by some women, or their partners, simply because it was viewed as more advanced than other forms of test. When asked why the digital test provided the extra surety she sought, Leila explained that “you probably just trust whatever computer magic is inside the test”.

Here we see that Leila was more trusting of the “computer magic” in the digital test, than her interpretation of a faint line produced by the standard tests she used. The gravitation towards more advanced models of the pregnancy test by some of my participants may be described with reference to the ‘technological imperative’. The concept has been used by authors accounting for the preference for the latest technological developments, and proposes that the mere existence of a new medical device provides a mandate for its use (Fuchs, 1972; Koenig, 1988; Dumit and Davis-Floyd, 1998). The phenomenon has been discussed widely in relation to pregnancy, for example in Georges’ (1996) observation that her Greek participants preferred to

attend hospital as opposed to the private clinic, because of the greater availability of machines. For one of my participants, the digital test was so highly valued that she perceived its result to be authoritative, and unlike many others, did not expect her GP to perform a pregnancy test:

I thought well I've gone for the Rolls Royce of pregnancy tests there so, erm, so perhaps, he'll be like well, there's no point, erm. So I didn't, really expect him to do a pregnancy test, so, I wasn't really perturbed when he didn't
Nancy, 25-29, 11 weeks pregnant

My participants as a whole, however, demonstrated that this draw towards technology was far from simple, and as articulated by Leila, depended on individual experience, including confidence in their interpretation of previous tests. This begins to hint at how my interviewees' interactions with the medical technology and care they experienced were shaped by and dependent upon other forms of knowledge, discussed further in Chapters Five and Six.

4.2.2.4 Negotiating a result

Detecting a pregnancy may therefore be experienced as a more complex undertaking than the instructions enclosed with tests might imply. As we have seen, users projected distinct meanings and assumptions into these technologies. For many the process involved work to decipher ambiguous symptoms, followed by making sense of the many types of test available and at which time they could be used. Interpretation was also required of women, and often their partners, in reading the result. I suggest that, like conception, the diagnosis of pregnancy was an uncertain, or 'tentative' experience. The majority of my participants, ten interviewees, were hesitant to accept an initial positive result, and took a further one or more tests. As we have already seen, various reasons were given for this, including participants' lack of confidence in their own interpretation of the test, and a desire to confirm a result using the most advanced technology available to them. However, even some of those who had received a certain result were hesitant to accept it as real or correct. Nancy explained:

On the way back from the doctors I went to [a supermarket] and bought three more pregnancy test packs, so that was six tests, erm, and I did three of them, and they all came back pregnant...I just thought well what if I've got a false positive...I thought right, so I'll just do some more, and reduce the risk that I've got the wrong answer here.

Nancy, 25-29, 11 weeks pregnant

Here, despite having received an initial result that was clearly positive, Nancy wanted to double check that this was correct. The hesitancy in accepting a positive test result was also exemplified in participants' first interactions with a health professional following their identification of a pregnancy. Just two of my participants were required to do a pregnancy test at their GP surgery before commencing antenatal care. Many of my interviewees found this unsettling, including Beth:

I thought, I went to the doctor, and they would do a urine test or a blood test, but I wasn't sure, and they would confirm 'yes you are'. No, seemingly they don't because pregnancy tests, are so effective, it's just like, well yeah you're pregnant, if you say you're pregnant then you're pregnant. Which is a bit weird.

Beth, 35-39, 11 weeks pregnant

After not being offered a test when informing her doctor of the pregnancy, Heather expressed her disappointment that her GP "didn't really do anything". Ingrid, however, was required to take a pregnancy test. She saw this as necessary, and explained:

I had to get a urine sample, from the medical clinic here, so that they could confirm I was pregnant, and log me into the system. Yeah. Cos they can't just take your word for it.

Ingrid, 30-34, 12 weeks pregnant

In the majority of cases, GPs seemed to grant expertise to participants in their ability to determine a pregnancy (though of course, this was provided they had used a technology viewed as appropriate). My interviewees' encounters with health professionals therefore destabilised understandings of 'authoritative knowledge', described in Chapter Two. In the extracts above, interviewees were positioned by GPs as possessing authoritative knowledge that was not seen as necessary to confirm

with further medically situated knowledge or technologies. Participants themselves however, were hesitant to accept this positioning.

The professed discomfort felt by participants at not having their pregnancy confirmed may be connected to the experience of early pregnancy as tentative, discussed further below, and their resulting desire for reassurance. This was sought from a number of sources including Internet forums and health professionals. In some cases, reassurance was also obtained through the re-configuration of the pregnancy test's intended use. Three participants demonstrated this, using the pregnancy test not just to confirm a pregnancy, but to ensure it was progressing. This was achieved by testing multiple times in the weeks following a positive initial result. Andrea, who had experienced three miscarriages in the past, used multiple cardboard strip tests to provide her with reassurance:

I did lots [of tests] ...probably about thirty...you kind of know if [the pregnancy's] working because the line gets darker each day. And, the first two [pregnancies], the line didn't really get much darker...this [pregnancy] the line got dark quite quickly, so that's why I kept on doing the test, cos it's like a reassurance thing. That this one might work.

Andrea, 30-34, 9 weeks pregnant

Nancy used the digital test in this way, noting that the number of weeks displayed increased as she continued to test. As with technologies experienced further along in pregnancy, my interviewees did not adhere to the use 'scripted' for them in the test's design (Akrich, 1992). Instead, some reconfigured the technology to act as an instrument of reassurance. That these three participants sought reassurance from multiple testing is characteristic of the experience of their pregnancies as tentative (Rothman, 1988). It is to Rothman's concept that we now turn in more detail.

4.3 The tentative pregnancy

Though all of my interviewees had received a positive test, and were experiencing (or had experienced) physical signs of pregnancy by our first interview, these indications were not taken to guarantee that they were pregnant, much less that they would have a healthy baby. Indeed, some interviewees remained unsure as to

whether they were (still) pregnant by the time we met for our first interview, which took place with my participants at between eight and twelve weeks' gestation.

This uncertainty was emblematic of participants' experiences of early pregnancy, which here is understood as the first twelve weeks, or the first trimester, of pregnancy. The experiences articulated by women with regards the reality and potential success of their pregnancy resonated with Rothman's (1988) concept of the tentative pregnancy, introduced in Chapter Two. Rothman explains that in anticipation of, and once having undergone amniocentesis, the future of a pregnancy is rendered unknown, due to the introduction of a possible abortion. Women are thus placed in a position of uncertainty with regards their engagement with their pregnancy:

A woman's commitment to her pregnancy under the conditions imposed by amniocentesis can only be tentative. She cannot ignore it, but neither can she wholeheartedly embrace it...the pregnancy may not be leading to a baby but to an abortion (1988: 101).

In Rothman's account this experience was prompted in the second trimester, when women may have begun to experience foetal movement, and is attributed to their encounters with a specific diagnostic technology. Based on interviews with my fifteen participants, I argue that the experience described above is also applicable to women's contemporary experiences of pregnancy outwith diagnostic testing. For my participants this was particularly evident during the first twelve weeks. Where Rothman refers to encounters with amniocentesis, the women I interviewed gave the impression that being pregnant *in itself* automatically put them at risk of losing the pregnancy. This was due to their knowledge of the increased risk of pregnancy loss during this period, communicated to them through medical discourses, and substantiated by experiential knowledge.

4.3.1 Miscarriage and the first trimester

A recent estimation of the rate of miscarriage in early pregnancy gives a figure of 12-24%: however, because some women may be unaware that they are pregnant, this is

likely to be underestimated (Jurkovic et al., 2013). I did not ask my interviewees about miscarriage during interviews, nor was the subject of risk a part of the topic guide. However, all but one of my participants (Ingrid) at times framed their talk in terms of the possibility of pregnancy loss. The majority were keenly aware that miscarriage rates were at their peak during the first twelve weeks of pregnancy, and perceived a pregnancy loss to be a very real threat. Nancy, for example, explained:

When I very first found out, like every time I went to the loo I was like looking for blood.

Nancy, 25-29, 11 weeks pregnant

Deborah described similar apprehensions. Though not all participants reported such strong sentiments, most projected a sense that the continuance of their pregnancy was not certain. Respondents discussed the perceived risks to their pregnancies in many ways, with Eve explaining that miscarriages are “common” during the first twelve weeks, and Deborah said that at this time “tonnes and tonnes of pregnancies end in miscarriage”. The majority invoked statistics during interviews, with the most common being that ‘one in four’ pregnancies end due to miscarriage during the first twelve weeks, related to me by four participants. Three participants used the statistic ‘one in five’. Some had obtained these figures directly from health professionals, and others from the Internet or pregnancy books. For example, Heather explained that “the NHS booklet kind of, explains about things that can go wrong, chances of miscarriage”. Felicity had seen a poster about miscarriage, giving the statistic one in four, on the wall of her GP surgery. However, there also seemed to be an inconsistency in the figures participants received:

It's a little bit confusing because different people have said different things but, I think [my husband, a GP] told me like one in, one in five pregnancies end in miscarriage...when I went to see the GP although he was brilliant, and really helpful and nice, he then said one in every three...and then I read somewhere else one in seven so, I just felt a bit like, like they need to get their numbers straight.

Keira, 30-34, 12 weeks pregnant

Here, Keira was keen to establish an ‘exact’ figure, demonstrating her preoccupation with miscarriage risk at this stage, but also her willingness to conceptualise such statistics as an accurate representation of the reality of early pregnancy loss.

Scholars have described how women’s contemporary experiences of early pregnancy in terms of a possible pregnancy loss may be linked to the widespread availability of home pregnancy tests. Han (2014) describes that a side effect of early pregnancy testing has been the phenomenon of a ‘chemical pregnancy’ (a pregnancy that develops no further than its detection). She asserts that the early acceptance of pregnancy allowed for by such tests *creates* experiences of first trimester miscarriage and pregnancy loss, causing women worry and suffering, and making them more vulnerable to blame (2014: 49) (this may of course be nuanced by the experiences of my participants, who maintained a ‘tentative’ acceptance of their pregnancy). Layne (2009) thus problematises the positioning of the home pregnancy test as a ‘feminist technology, due to the fact that this technology reduces pregnancy to the presence or absence of the hormone hCG. This is without acknowledging that some users will not want to continue with their pregnancy, nor do they point to the possibility of miscarriage (2009: 74).

However, as also discussed in Chapter Two, though scholars often attribute the construction of pregnancy as a time of risk to medical discourses and technologies, interviewees also drew on experiential knowledge to account for their concerns about early pregnancy loss. Eight of my participants gave anecdotes about friends of family members who had experienced one or more unsuccessful pregnancies. For example, Sinead described:

The doctor was basically like ‘I’ve got to say this’, you know, one in four pregnancies do fail...but uh, we’ve got friends, lots of friends who’ve had miscarriages. Um. Some quite late in fact. Uh. So it wasn’t really, it wasn’t like never a possibility.

Sinead, 25-29, 11 weeks pregnant

Experiences drawn on included multiple miscarriages, blighted ova (where a fertilised egg does not successfully develop into a viable pregnancy, often without

symptoms), and what several participants described as “missed miscarriages” (referring to a miscarriage late in the first trimester, which may only be discovered at the twelve week scan). The awareness of these experiences of friends and family, which Abel and Browner (1998) term empathetic experiential knowledge, made the statistics and risk of miscarriage, already interpreted as high, very real for participants. Indeed, Leila linked these directly to her own perceived risk, referring to the experiences of her husband’s female relatives as her “family history”.

Along with the knowledge of others who had experienced a miscarriage, women’s anxieties regarding pregnancy loss were also reinforced by their understandings of foetal development. All of my participants engaged with weekly email updates featuring visual depictions of the foetus at various stages, obtained from popular sources such as pregnancy-themed Internet forums and the BBC website. During the first twelve weeks these provided further evidence of the vulnerability of their pregnancies:

I can just read the facts, you know, like uh, loads, tonnes, tonnes of pregnancies end in miscarriage...just thinking about like, the baby, like reading about the organs I mean it’s developing all of these organs, from scratch, and it’s just like so many possibilities for things to go wrong.
Deborah, 35-39, 12 weeks pregnant

Andrea, who as noted above had experienced multiple miscarriages prior to her first interview, was particularly mindful of the possibility of pregnancy loss. In the quote that follows we observe her engaging in emotion work, discussed further below, by moderating her “excitement” in response to her past experience of pregnancy loss. Like Deborah, she describes the increased risks before twelve weeks in terms of foetal development:

I told...a friend yesterday...and she said ‘I’m just wondering if I can get excited?’ and I had to say, well no, you can’t get excited because, I’ve been pregnant, it’s lovely and great, but I’m so aware that it doesn’t turn into a baby. But after a twelve week scan, it’s quite different... all their organs are formed, the chances of things going wrong after then are so much smaller.
Andrea, 30-34, 9 weeks pregnant

Such descriptions resonated with the majority of participants' embodied experiences during the first trimester. The pregnancy remained uncertain for many due to the lack of evidence of an established pregnancy. For example, Beth reflected that "it doesn't feel quite real yet, because I don't have a bump". Deborah explained "it's really hard right now, you just feel like...you're diseased or something". Keira and Leila gave similar accounts. Gail attributed this in part to the fact that she had not been tested for pregnancy by a health professional, saying "nobody's checked. You could still be just like making it up". For many interviewees, feelings of uncertainty with regards the reality and success of the pregnancy were therefore embodied, as well as communicated to them through medical discourses of pregnancy loss. The unfamiliarity with the changing experiences of their bodies, which for many was characterised by the experience of sickness at the time of our first interview, I would argue contributed to an 'at-risk' consciousness (Robertson, 2000) whereby the unfamiliar and at times unpleasant experiences of the body in early pregnancy contributed to a sense of uncertainty and vulnerability, and thus to their experience of early pregnancy as tentative.

Multiple factors therefore contributed to women's understandings of the risk of pregnancy loss in early gestation. As we have seen, their anxiety was grounded in numerical representations of miscarriage risk, received from both professional and informal sources. That the possibility of miscarriage was so often repeated and feared is perhaps attributable to its particular communication, in terms of the very intelligible, but also decontextualised statistic of 'one in four' (or for some 'one in five'). Rapp explains that when presented in this way, such figures appear as universal, failing to account for the health status of the individual, nor the context in which their pregnancies take place (Rapp, 1995: 181). However, women's personal experiences also had an important part to play in their experience of being at risk of miscarriage. The many anecdotes regarding friends and family members related during interviews, and participants' explanations for the vulnerability of the foetus during early pregnancy, further substantiated the more formal discourses of risk they consumed. My participants thus engaged with medically-based information regarding risk reflexively, judging this to be 'credible' because it was congruent with

their own rationalisations and experiential knowledge (Wynne, 1992; Pickersgill et al., 2014).

As a consequence of this, interviewees were eager to reach the twelfth week of pregnancy. This was important for two reasons. To begin with, this marked the point at which the risk of miscarriage is interpreted, in obstetric texts and by women themselves, to be significantly reduced (it has been estimated that the rate of pregnancy loss reduces to 1-5% during thirteen to nineteen weeks' gestation (Michels and Tiu, 2007)).

[At twelve weeks] the risk's gone down massively. If it's there, and it's lived 'til then and its heart's still beating, then you're like, more than 99% chance that you're going to have a baby.

Gail, 35-39, 10 weeks pregnant

Secondly, participants noted that they would have their first routine scan at this time. This was viewed as an important event at which they could confirm their pregnant status, and ascertain that the pregnancy was progressing as hoped.

At the minute I'm starting to worry about, yeah, will there be a heartbeat, and all that kind of thing...I just want to be sure that everything's OK. But as soon as we see that everything is OK, I'll be very open about it.

Beth, 35-39, 11 weeks pregnant

Throughout this chapter so far we have seen that participants experienced early pregnancy as at risk of pregnancy loss. Miscarriage was seen as a salient threat; in Caroline's words, the risk was "very significant". The resulting uncertainty felt by participants at this stage resonated with Rothman's (1988) concept of the 'tentative pregnancy'. Due to their heightened awareness that the pregnancy may end, and its resulting status as tentative during the first twelve weeks, my participants' accounts reflected a reluctance to "wholeheartedly embrace" (1988: 101) their pregnancy. To manage this ambiguous and uncertain position, women seemed to actively regulate their emotions regarding the pregnancy. Since their pregnancies were wanted and an important step towards a desired future, it was not only the pregnancy, but also their emotional wellbeing, that were particularly at stake during the first trimester.

4.3.2 Enacting the tentative pregnancy: emotion work and the ‘twelve week rule’

As outlined in the introduction to this chapter, Rothman’s concept has been influential in discussions of women’s experiences of medical intervention and reproductive technologies. Despite this, women’s approaches to managing tentativeness during pregnancy, particularly marked for my participants during the first trimester, have rarely been explored. In what follows, I propose that emotion work was an important strategy used by women to manage tentativeness. An aspect of this was the decision to withhold news of their pregnancy with wider friends and family for the first twelve weeks.

During our first interviews, participants regularly described specific emotions, both experienced and imagined, including ‘excitement’, ‘devastation’ and ‘happiness’. They also described their efforts to manage these. These experiences resonated with Hochschild’s concept of emotion work, described as the “act of evoking or shaping, as well as supressing, feeling in oneself” (1979: 561). Emotion work has been used to describe the efforts made by individuals to regulate their feelings in accordance with “feeling rules”: social guidelines regarding the display and even experience of emotions deemed appropriate to a situation (Hochschild, 1979). Though individuals may be required to mobilise techniques of emotion management for commercial purposes (Hochschild, 1983), here I use the term to describe the work performed by my participants to manage their own feelings for *personal* ends. This is as opposed to achieving a change in the feelings or experience of others, demonstrating that emotion work may not always be altruistic (Exley and Letherby, 2001)

Interviewees often articulated efforts to repress positive emotions due to their interpretation that the pregnancy’s success was not guaranteed. For example, Felicity said:

I guess it’s just kind of ingrained into you that after twelve weeks, [a miscarriage is] less likely to happen. Erm, so, yeah, I don’t, I don’t feel that I

can get excited because I don't want to then be, more upset when we get, if we get the news that, you know, something's gone wrong.

Felicity, 25-29, 10 weeks pregnant

Similarly, Keira explained:

I was a little bit, trying so hard not to be too excited at the start, because [I] kind of knew that it doesn't always work out...I just thought, if I build it up too much it's gonna be really heart breaking so, I was trying to contain my excitement, but it's quite difficult.

Keira, 30-34, 12 weeks pregnant

Here Keira and Felicity clearly articulate their efforts to repress excitement, and entwined with this, prepare themselves for the possibility of miscarriage by trying to limit the amount of “heartbreak” or “upset” they expect to experience should this occur. Two interviewees, Sinead and Andrea, described such activity as ‘self-preservation’. Most participants articulated similar attempts to suppress their excitement about the pregnancy during our first interview. This could comprise of trying not to think too far into the future. For example, Gail described her attitude towards the pregnancy as “let’s see how it goes”.

We see then that participants described pleasure at the prospect of a future baby. However, they had to balance this with the risks they perceived to early pregnancy. This resulted in a ‘tentativeness’, where they appeared to “keep a distance, emotionally and pragmatically, from the baby” (Rothman; 1988: 103). We will now turn to a practice through which participants outwardly ‘did’ emotion work: keeping the pregnancy a secret from wider friends and family for the first, most risky, trimester.

4.3.2.1 The ‘twelve week rule’

The convention of keeping one’s pregnancy a secret during early gestation, which I refer to here as the ‘twelve week rule’, was a familiar aspect of my participants’ experiences of pregnancy, and has been noted in previous research (Rothman, 1988; Ross, 2012). Efforts made by women to maintain a silence with regards their early pregnancy are observable on Internet forums, which often feature discussions of

‘how to keep pregnancy a secret’, and it is also discussed in the advice provided to women by the National Health Service (NHS). In Scotland, this is represented by the publication *Ready Steady Baby!*. In a section named ‘When to tell people’, the booklet explains

Most people wait until the end of the first trimester (after 12 weeks) until they announce they are pregnant. That’s the stage where there is much less risk of miscarriage, and you have had an ultrasound scan and even seen your baby on screen (NHS Health Scotland, 2012: 34).

The framing of the first twelve weeks of pregnancy as particularly ‘risky’ is evident here, and its presence in the material provided to pregnant women on their first encounter with a GP or midwife goes some way to explaining women’s preoccupation with reaching the end of this period.

All of my participants adhered to this secrecy in some form. Most participants told close family (parents and/or siblings) about the pregnancy during the first trimester. However, they refrained from telling wider friends and family until they had reached twelve weeks gestation (though, as we shall see this was not always successful). Two participants wanted to wait until they had undergone their first scan before telling *any* family members. The reasons given for withholding the news from others related to the perceived possibility of miscarriage during these first twelve weeks:

[It’s] just to make sure that you don’t have to tell them about a miscarriage in the end, yeah. I would only tell people that I would be fine with telling about miscarriage as well.

Julia, 25-29, 10 weeks pregnant

We haven’t told any other wider family or friends, yet. Because we both felt we wanted to wait ‘til a bit further down the line, and...know that, you know, the first twelve weeks is, is you know, not a definite and things can go wrong.

Heather, 30-34, 10 weeks pregnant

For those participants who did share the news with their close family, they nevertheless felt it necessary to qualify news of the pregnancy with the caveat that a successful pregnancy was not guaranteed at this stage. Some gave this as a reason for waiting for their first scan to tell others, because it would enable them to tell people

without having to warn others that it is “early days”. It was anticipated that this would increase their enjoyment of sharing the news:

At first we thought, oh we'll tell parents and stuff, about eight weeks or something...we could have said 'oh, I'm pregnant but it's very early days yet'...then I thought it'd just be much easier, simpler, and you could just be like, across the board, just, kind of happy, without kind of, any provisos, if you have that scan picture.

Gail, 35-39, 10 weeks pregnant

Withholding news of the pregnancy, I suggest, can also be interpreted as contributing to interviewees' emotion work, providing a further means through which they could create and maintain a “distance” (Rothman, 1988: 103) from their pregnancy, and the foetus. Indeed, women associated telling others the news with ‘getting excited’ about the pregnancy, an emotion they were trying to contain. Heather explained that telling her family about the pregnancy made it seem more “real”. Leila felt this too, and said this was “no bad thing, but...you kind of get scared. Cos it's so new, and you just don't know do you?”. When discussing how she shared the news with her close family, Beth reflected: “it's early days...you don't want to get too attached to the idea just yet, because you just don't know”.

The majority of participants did not provide further explanations for why they would not want to tell others about a miscarriage. However, from the examples above it seems participants understood that any emotional distress following a miscarriage would be exacerbated should others know about the pregnancy. Ingrid, however, gave the reason that she did not want to be “pitied” should she suffer a pregnancy loss. Their unwillingness to share news of a miscarriage with others, should this occur, thus took precedence over their desire to be honest with those in their social networks, further indicating that participants felt miscarriage to be a very real threat to their pregnancy.

Miscarriage, and other forms of reproductive loss, have increasingly become subject to analysis in the social sciences (e.g. Cecil, 1996; Earle et al., 2012). Existing literature has noted the issue of secrecy in early pregnancy, with some suggesting

that the unwillingness shown by women to discuss pregnancy loss may be due to a discomfort with the topic of foetal death (Layne, 2003). Layne's (2003) ethnographic account of pregnancy loss laments the silence around miscarriage, attributing this in part to the liminal status of women, and superliminal status of the embryos/foetuses it creates (2003: 64). Discomfort regarding death more generally may also shed light on why miscarriage remains a taboo. Mellor (1992) argues that though increasingly engaged with in academia, death largely remains a hidden subject, sequestered from public space. Miscarriage, being an even more hidden form of death, a uniquely private one occurring through women's bodies, further challenges our understandings of the end of life, especially when that which is lost is an unstable entity (Williams et al., 2001), a conceptualisation which may also be held by women themselves (see Chapter Five). It is also possible that the taboo status acquired by miscarriage may be linked to issues of guilt and responsibility, with women often positioned as solely responsible for the health and wellbeing of the foetus (Wetterberg, 2004), and therefore potentially for its loss. The few participants in my research who discussed a potential miscarriage, however, did not invoke such sentiments.

Existing literature has touched on the secrecy employed by women during the first months of their pregnancy, linking this to the silence surrounding miscarriage (Reinharz, 1987: 234; Layne, 2003: 70). However it is difficult to find broader discussion of this phenomenon in the social sciences, particularly featuring the voices of women themselves. My research found that women engaged with this silence in early pregnancy in different ways. Though, as we have seen, most gave not wanting to tell people about a miscarriage as a reason for withholding their news, some gave additional reasons. For example, Gail was self-employed, and concerned that should she tell her friends about her pregnancy, a colleague with whom she shared social networks would find out, affecting her job prospects. Similar concerns were also articulated by women in Gatrell's (2011) research. Here, women's secrecy with regards their pregnancy was interpreted as a strategic response to the rejection of pregnant bodies or discrimination in the workplace. However, a consideration of

gestational time may also have revealed concerns particular to the first trimester, in line with the experiences of my participants.

Heather also highlighted her desire to keep the pregnancy as something “magical”, solely for herself and her husband, as a reason for withholding the news from others, a reason also touched on by Keira and Deborah. A possible pregnancy loss as a result of miscarriage was not the only concern leading women to maintain silence. Deborah also pointed to the possibility of the ultrasound scan detecting a foetal anomaly, which provided further justification for waiting until the first scan to tell any of her friends and family, including her parents:

I’m probably gonna tell my parents after the scan. But I’m just like, we’re ...realistic about the fact that, you know, until you see the baby that, like, there could be things that we don’t know.

Deborah, 35-39, 12 weeks pregnant

Later in her interview, however, it appeared that Deborah’s decision not to share news of her pregnancy with close family was not solely to protect herself from the emotional distress of having to tell people about a possible miscarriage or abortion, but also to protect those close to her:

My parents want a grandchild more than anything in the whole world, and so I just wouldn’t want to tell them, and then a week later say ‘actually, we’ve lost it’. I just think it would be too traumatic.

Deborah, 35-39, 12 weeks pregnant

It seems here that Deborah equated losing the pregnancy with her parents losing a grandchild, the potentiality of which is introduced merely by virtue of her being pregnant. However, it is notable that Deborah herself did not talk about a possible miscarriage in this way. For Deborah, the pregnancy was “abstract”, and the status of the foetus uncertain (this is discussed more in Chapter Five). The desire to protect family members was also articulated by Caroline and Keira, who were particularly anxious about sharing news of the pregnancy too early with their older female relatives. These stories suggest that the suspension of emotions towards the foetus during the tentative period of pregnancy was not perceived by participants as unique

to pregnant women, but also necessary for wider family and social networks, who are also seen to develop attachments to the foetus (see Taylor, 1998; Han, 2009b; Harpel and Hertzog, 2010 for discussion of how the ultrasound scan contributes to the formation of foetal kinship connections with wider family).

As highlighted above, the reason most often articulated by participants for keeping their pregnancy a secret from others was the prospect of having to share news of a miscarriage with others, should the pregnancy fail. Participants discursively connected this concern to biomedical accounts of the risk of miscarriage in early pregnancy. However several participants also brought the apparently contrasting notion of ‘fate’ into their narratives. Participants often qualified their discussions of the pregnancy with “touch wood” (Beth), or of the scan “fingers crossed” (Nancy). Leila explained that she has not told many people about the pregnancy because she didn’t want to “tempt fate”. This way of describing the risk of miscarriage, likening it to fate, reflects how powerless the women I interviewed felt with regards the possibility that the pregnancy may fail. Marisa seemed keenly aware of this:

Things might happen which are completely outwith my control...that's just the way life is sometimes.

Marisa, 35-39, 9 weeks pregnant

4.3.2.2 Keeping the secret

Many obstacles threatened my respondents’ efforts to maintain their secrecy for the first twelve weeks of pregnancy. For example, Julia worked in a laboratory housing viruses, some of which she was told posed a particular risk to premature babies. She was therefore impatient to discuss her pregnancy with her manager to arrange a risk assessment, but was adhering to the secrecy expected of her. We see here that for Julia, the risk of a possible miscarriage, and having to then discuss this with others, seemed more of a threat than the risk of her pregnancy being adversely affected by her working conditions (though she was confident that safety regulations were already strict).

Others described feelings of guilt at deceiving their closest friends; this was most often discussed in the context of refusing alcohol whilst at social events. Participants often used false explanations - including that they were taking antibiotics or had an upset stomach - to account for refusing alcoholic drinks. To avoid this deception, some participants would forgo socialising with friends during the evenings altogether:

I don't mind the not drinking...I just wanna go out and be able to be open and chat with people as opposed to feeling like, and I mean it was our choice, but I just, [my husband] and I are private like that.

Deborah, 35-39, 12 weeks pregnant

The 12 week secrecy rule they imposed upon themselves also meant that the women I interviewed were unable to explain changes in their behaviour or appearance to others. As Leila reflected: "it's the one thing you really want to tell people. You want them to know you're not being, crap by not drinking and, you know, going to bed early". This was especially difficult in the workplace. 'Morning sickness' affected all but two of my participants, and two described telling their managers about the pregnancy because of this. Keira, however, did not feel she could:

I still haven't told anyone at work so I was trying, putting on a brave face and that was quite hard. I felt really, I felt really sick, and really, really tired.

Keira, 30-34, 12 weeks pregnant

After maintaining secrecy for as long as she could, Heather told her manager that she was pregnant. She described this as alleviating the stress she experienced in hiding her pregnancy symptoms, and explained that her manager now allowed her to leave work early if she needed to. We see then, that despite the relief that came from telling others about the pregnancy, and that working life in particular was made easier, women remained reluctant to share their news.

I would like to return here to Deborah's assertion that despite the difficulties it posed, it was her and her husband's "choice" not to tell others about the pregnancy. The notion of choice in pregnancy has often been discussed in existing literature, particularly in relation to reproductive technologies (e.g. Gregg, 1995; Potter et al.,

2008; Browner and Preloran, 2000). These authors argue that choices are often constrained by cultural or familial expectations, doctors' recommendations, and wider social influences on choices, for example with regards to whether to terminate a pregnancy in the case of a genetic disability (Lippman, 1999a). In such cases, women must negotiate ethical dilemmas in complex contexts, and are thus situated as 'moral pioneers' (Rapp, 1988; Williams et al., 2005). As outlined in Chapter Two, pregnancy and childbirth are particularly open to the scrutiny of others. To keep one's pregnancy a secret for the first three months was articulated by my interviewees as an expected part of pregnancy, and may be seen as important aspect of its successful performance (Neiterman, 2012). When asking whether they had told others about their pregnancy during our first interview, I sensed that participants felt they had to explain their reasons for having told those outside their close family about the pregnancy. The notion that it was inappropriate to take the pregnancy for granted, for example by sharing news of the pregnancy before twelve weeks, was implied by Sinead, who during our last interview described a friend who had recently experienced a miscarriage at nine weeks pregnant:

When she'd found out that she was pregnant she'd sort of told us a bit earlier...she was really excited and want, and um was doing the er, you know, looking online for everything...like more organised. And then obviously she ended up um, losing her baby.

Sinead, 25-29, 11 weeks pregnant

Sinead implied that her friend had "taken it so badly" because she had become excited about the pregnancy too soon. Similarly, when a colleague announced her pregnancy at work during the first trimester, Nancy reflected that "I probably wouldn't say anything at ten weeks". We see then that the twelve week rule was not only imposed on my participants by themselves, but was also expected of them by others. Indeed, individuals in my interviewees' social networks also recognised efforts to adhere to the twelve week secrecy convention. Many of my participants suspected that their friends had already guessed that they were pregnant, due to the fact that they had "reached a certain point" in their lives (Keira), or because of their changed behaviours such as abstaining from alcohol (Beth). That their friends did not say anything, however, demonstrates the pervasiveness of the twelve week rule; a

‘public secret’, representing a powerful form of social knowledge (Taussig, 1999), whereby discourses of risk surrounding early pregnancy have created subjects who ‘know what not to know’.

4.3.2.3 *Bending the rule(s)*

For some of my participants, the possibility of miscarriage was prepared for by selectively and purposefully *telling* people their secret. Leila described her decision to share the news with some of her friends.

I’ve only told people who [I] trust to know, and also people who, if it were all to go wrong at the scan, you know, if it were to end before the end, I know they would support me through it.

Leila, 30-34, 11 weeks pregnant

Though we see that Leila appears to have defied the secrecy convention, her reasons for doing so are the same as for those who adhered to it more strictly: she feared a pregnancy loss. For Andrea, who had experienced recurrent miscarriages before her current pregnancy, it was important that she did *not* adhere to the first trimester of secrecy generally expected during pregnancy. She explained:

Yeah, this time we’ve told actually quite a lot of people...but everyone is now made aware that it may or may not work...I’ve told my closest friend, and a couple of, one colleague, um, because after last one I had time off work and had problems, that I wanted support.

Andrea, 30-34, 9 weeks pregnant

The convention of keeping one’s pregnancy a secret until the end of the first trimester is thus a flexible phenomenon, adapted to individual participants’ social networks and reproductive history. The length of time one kept the secret was also flexible. In her second interview, Deborah explained that after telling her parents the news following the scan at twelve weeks, she requested that they keep it a secret for a further two weeks:

We didn't tell most people until like fourteen weeks, cos I just wanted to be like, over over, and also like, while the news was so exciting, it was still very personal, it's like, this is our baby.

Deborah, 35-39, 19 weeks pregnant

Here, though she was operating within a threshold of twelve weeks being the riskiest time, Deborah wanted to be extra sure that she was into the 'safer' period, but also wanted to keep the news between her and her husband for a little longer. Though they told their wider family and friends after twelve weeks, Heather and Keira also expressed similar sentiments regarding privacy. Marisa similarly imposed her own interpretation of when it was 'safe' to tell others, by waiting until she received her personalised estimation for the risk of Down's syndrome¹⁰. She explained:

We still sort of weren't quite in the clear, in that respect...I mean it was great to see it, at the scan, but I still wasn't 100% sure that it was OK.

Marisa, 35-39, 19 weeks pregnant

It was not until she received her risk of Down's syndrome, which she interpreted as "infinitesimally small", that she felt she could relax about the pregnancy. Though an ultrasound scan showing no anomaly is often seen to objectively confirm the health of the foetus, this was not taken to be sufficient by Deborah and Marisa. The information was interpreted in terms of the high level of risk they still saw to the pregnancy at this early stage.

As indicated earlier, both the fact that the first trimester had ended, a time during which the most important aspects of foetal development were seen to take place (and supported by the pregnancy information they received (see NHS Health Scotland, 2012)), and the fact that they would see the foetus on screen, were important to reach before participants felt they could share the news with wider family and friends. Julia demonstrated this further by planning to keep her pregnancy a secret until she had seen her first scan, which was not scheduled until her fourteenth week of pregnancy.

¹⁰ This estimation, presented in terms of odds, is achieved by combining results from a blood test, maternal age, weight and a measurement taken at the 12 week ultrasound scan (NHS Health Scotland, 2014, p. 31).

4.3.3 Methods of reassurance: milestones and medical authority

In the face of the high risk of an adverse pregnancy outcome perceived by my participants during the first twelve weeks, they sought information from various sources in response to the uncertainty articulated at this stage. In the absence of the support of wider family and friends, participants often turned to message boards on various Internet forums, such as *babycentre.com*, *netmums.com* and *mumsnet.com*. *Baby Centre* proved the most popular with participants, offering ‘Birth Club’ message boards, providing a space to discuss or read about issues experienced by other women at a similar stage of pregnancy (the Birth Club message boards are accessible according to the month in which members are due to give birth). These message boards were described by interviewees, including Julia and Andrea, as “reassuring”.

Some participants explained that a large part of their use of the Internet at this stage was to seek reassurance. Seeking reassurance is also reported to form a large part of patients’ interactions with medical professionals, including midwives (Donovan and Blake, 2000), and medical artefacts (McDonald et al., 1996). During this early period of pregnancy, my participants seemed to accord particular credence to medical knowledge of their pregnancies, designating it as authoritative. For example, participants were keen to speak with their GP following a positive pregnancy test, and as previously discussed, expected some form of confirmation of the pregnancy. The booking appointment was a much anticipated milestone, and assisted interviewees in making the pregnancy feel real, or as Keira described, “more exciting”:

[My GP] put me on the midwife list, and gave me a bunch of, a booklet with information about dos and don'ts, gave me a timeline which gave me some reassurance...I got a letter in the mail with a midwife appointment, then that felt more real, you know, feeling like, 'oh well they know I exist'.

Deborah, 35-39, 12 weeks pregnant

Eve did not have an appointment with her GP; the receptionist simply gave her a number on which to contact the midwife team. She explained she would have appreciated:

...checking in with your GP a bit more, and that reassurance that you get from them sometimes, that, yes, you know, them doing another test in front of you maybe or, going through some of the signs and symptoms.

Eve, 25-29, 9 weeks pregnant

Following the booking appointment, all but one of my participants felt positive, welcoming their first contact with a midwife. Some described this in terms of no longer being alone, such was the responsibility that they felt for the pregnancy.

I felt I was definitely, I'm very much in the system now, and, do it by the, do it by the system, really. Which, I don't have a problem with, I've never done this before so I'm happy to, um, I'm gonna do what I'm told really, these people are professionals

Marisa, 35-39, 9 weeks pregnant

*I went through this process where it was very medical, and you feel very safe and comfortable in that kind of environment...it's suddenly it's, it's not, it's still your responsibility **but it's not as much your responsibility**, cos if, I felt like I was, **I guess it was like being in the system**...it made me feel a lot more, um, relaxed and happy and optimistic.*

Caroline, 35-39, 8 weeks pregnant. Emphasis added.

Caroline's extract demonstrates that her experience of the tentative pregnancy - exacerbated by her concerns about having consumed alcohol around the time of conception - was abated by her contact with medical professionals, to whom she granted expert status and thus derived reassurance. Caroline also demonstrates how the burden of responsibility she felt for the pregnancy at this time, being unable to share the news with wider family and friends, was lessened through her interaction with a health professional. In a similar vein, participants welcomed the tests they received at each midwife appointment, with five, including Andrea and Deborah explaining "I'd rather know". Test results provided participants with some form of control and knowledge of their pregnancy, in the face of the uncertainty characteristic of the first trimester. Some participants were therefore eager to have contact with their GP to ask about the foods they should avoid, and specific activities such as hot baths or forms of exercise. The notion that reassurance can be *gained* from coming under the surveillance of medical professionals is also discussed in Parsons et al's research with women at risk of familial breast cancer (2000). Scott et

al's study also described that participants sought a 'high risk' status due to the additional surveillance they would receive (2005), discussed in Chapter Two.

Early research exploring the medicalisation of pregnancy, such as that by Graham and Oakley (1981), has described pregnant women and medical professionals as holding competing ideologies with regards expertise and the designation of control in pregnancy. In their work, these are presented as fundamentally dichotomous and in conflict. However, my research found women's ascription of authority, and desire to relinquish control over their care, was fluid, varying between participants who all had different reproductive histories. As we shall see later in this thesis, this also varied over the nine months of pregnancy. I venture that during this early stage of pregnancy, when my participants felt vulnerable, according authority to medical knowledge may be understood as a strategic action in the search for reassurance; at this time medical sources offered one of the few forms of knowledge they could access. Ascribing authority to medical knowledge of pregnancy then, could abate (as well as provoke) uncertainty during the early stages of pregnancy, demonstrating the importance of considering gestational time in discussions of sources of knowledge in pregnancy.

In a further example of their search for reassurance from biomedical accounts of pregnancy, though participants found it difficult to manage the sickness they experienced at this time, they welcomed this as a sign that they were still pregnant, with Julia describing this as indicative of "hormone levels rising". However, an adverse effect came when interviewees interpreted medical discourses as signalling how they *should* be feeling. Perhaps as a result of their uncertainty at this time, my participants often saw medical resources, such as the week by week diagrams of development obtained from popular (e.g. websites) and medical sources (e.g. *Ready Steady Baby!*) to provide prescriptive accounts of pregnancy symptoms. For example, Heather saw such information as providing descriptions of "what your body should be doing", and Julia explained that she "know[s] from websites what's supposed to be happening". This is also noted by Han in her research with pregnant women in America, where participants mistakenly cited a subtitle in a popular

pregnancy book as "what you should be feeling" (2013: 41). Viewing these resources in this way led Leila to question her experience of pregnancy:

It gives you like a week by week how you should be feeling and, what your baby's doing, that kind of thing, I've felt about two weeks ahead, the whole time.

Leila, 30-34, 11 weeks pregnant

Leila was concerned that she could not explain the premature appearance of certain symptoms. After her twelve week scan, where the due date given was not far from her original estimate, she remained unable to account for feeling 'two weeks ahead', which made her uneasy. For Andrea, viewing medical knowledge of pregnancy as prescriptive led her to become anxious about the health of the foetus. This occurred in the context of past miscarriages, whereby one had been due to a chromosomal abnormality. In the quote below, Andrea ascribes to, but then subsequently reinterprets the information she received from medical professionals, demonstrating the 'double-edged' nature of seeking medical advice and information regarding pregnancy, which has the potential to provoke both anxiety and reassurance¹¹:

We had a genetics test at eight weeks...I said 'oh our baby's a bit, it's a week bigger, that I thought it was. That's not a sign of Turner syndrome, which we had with the last pregnancy?' and she said 'oh no, it's not, big baby isn't a sign of Turner syndrome, having a large amniotic sac, or having extra fluid can sometimes be a sign'. So then when I saw that it had a massive sac, I kind of, it worried me a bit. It wasn't until...I Googled, um, that, in kind of a respectable place, cos I had kind of worked out that I don't think it makes any difference, and it's true.

Andrea, 30-34, 9 weeks pregnant

Here we see Andrea switching the credence she assigns to various forms of knowledge, initially fearing the worst in accordance with what the genetic counsellor had said, but subsequently, almost within the same breath, rejecting this. She assuaged her anxiety by drawing on her own methods, through Internet searches, and

¹¹ Referred to by Nettleton, in her discussion of individuals' apparent contradictory engagements with medicine, as 'ambivalence': "One wants to undergo 'tests' that might reveal the source of the problem and yet one does not...want to discover one has a life threatening disease" (2006: 1173).

also by comparing her scan image with a friend's. Participants had other methods of self-reassurance. This included through talk; I noticed that during interviews, when talking about the potential for things to go wrong in pregnancy, interviewees would often voice their reasons for thinking that the pregnancy was safe, for example explaining to me that they have never smoked or consumed alcohol excessively, that their symptoms had not faded, or that they had not had any cramps or bleeding during their pregnancy. Participants also reconfigured medical discourses as a method of reassurance. Internet forums and pregnancy websites aided this. For example, though the twelve week threshold was a well adhered to milestone, perceived to signal a decreased risk of miscarriage, three participants imposed additional milestones *within* this period;

With every week I've felt more and more confident. Five and six weeks were the hardest. Cos that's where like, you know, it's really just, the cells you know. Um, and now I feel much more confident.

Deborah, 35-39, 12 weeks pregnant

Andrea introduced eight weeks as a threshold where "a lot of babies die", and ten weeks was given by Sinead as another period at which the risk of miscarriage began to fall. Working with medical discussions of pregnancy in this way provided participants with a means of thinking positively in the face of uncertainty; however, this was also offset by their emotion work employed to keep themselves from getting 'happy' or 'confident' about the pregnancy, in case it should fail. Leila demonstrated this conflict during our second interview, whilst discussing the reassurances provided by the medical interventions she had received:

I kind of thought maybe I needed some more, extra iron, which would have been fine, but even that came back normal, so. And the Down's [syndrome screening] came back normal. Erm, all the glucose was normal, so in a way there's nothing really to worry about. But, at the same time I know [there] completely is as well.

Leila, 30-34, 19 weeks pregnant

This notion of having to balance two mind-sets with regards the pregnancy, one where it succeeds, and one where it does not, emerged as a strong theme throughout my interviews in early pregnancy, and is discussed further below.

4.4 Ambiguity in early pregnancy

Participants presented a sense of occupying ambiguous positions in early pregnancy. This was experienced in various ways, for example by simultaneously preparing for a successful and unsuccessful pregnancy, and shifting between conceptualisations of themselves as both pregnant and non-pregnant women. These are explored below.

4.4.1 *Betwixt and Between: early pregnancy as being ‘in limbo’*

During this early period of pregnancy, I was struck that participants seldom made mention of the entity growing inside them; exceptions to this were three participants, Sinead, Andrea and Felicity, who had experienced early scans (described in Chapter Five). However, even for those who had, talk of the foetus rarely occurred unless I asked questions directly about ‘what was inside’ them. More frequent was discussion of a future, imagined baby, though this also was regulated by participants’ experiences of their pregnancies as tentative.

I suggest that this is related to the fact that for the majority of participants, the pregnancy felt unreal at the stage that I met them for our first interview, despite them all having taken a pregnancy test. This is perhaps in virtue of the fact that many approached their pregnancy tentatively (and also contributed to the tentativeness they felt). Heather and Caroline’s statements were typical of all but one of my participants:

I’m not sure I’m quite connected to what’s happening you know, it feels, it doesn’t feel quite real.

Caroline, 35-39, 8 weeks pregnant

In a way it’s probably as unreal as it, you imagine it yourself.

Heather, 30-34, 11 weeks pregnant

Though all described their bodies as having changed in some way, and most had experienced symptoms of morning sickness, these were not always enough to convince them of the certainty of a pregnancy. Deborah and Gail described how for

them, their symptoms were not sufficient to indicate a pregnancy. Here, they use notions of ‘sickness’ and ‘disease’, reflecting the pathologisation of pregnancy critiqued in existing work (e.g. Barker, 1998).

It's really hard right now, you just feel like...you're diseased or something. A lot of the time you just feel ill.

Deborah, 35-39, 12 weeks pregnant

If I wasn't pregnant I would have been at the doctor a long time ago because I felt like absolute hell...it doesn't relate massively to being pregnant as such. It's more like, stomach and digestive issues.

Gail, 35-39, 10 weeks pregnant

I would liken this state of being and embodiment: of knowing that their embodied experience had changed in some way, but not yet able to accept the reality of pregnancy, to a period of ‘liminality’. This concept has been used to describe the transitional phase integral to ritual acts. In anthropology, Van Gennep’s early description of rites of passage, in which he outlined their constitutive phases of separation, transition and incorporation (1960: 11), was later adopted by Turner, who explored the transitional phase in more detail. During this period, participants in ritual are stripped of their previous identity, but have not yet been assigned a new status or role. The attributes of these persons are therefore ambiguous, “they slip through the network of classifications that normally locate states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between” (Turner, 1969: 95).

Pregnancy has been previously discussed in terms of liminality, but often in terms of the nine month period of pregnancy itself representing a liminal phase. For example, Han suggests that pregnancy is a liminal phase in the sense that during this period a woman transitions from “childless woman to mother” (2013: 68)¹². However, I would venture that *early pregnancy in itself* may be discussed with reference to

¹² However, it is necessary to highlight that a woman does not become a mother merely by going through the biological processes of pregnancy and birth; this is certainly true in the case of surrogate pregnancies, but also with those who have difficulty forming attachments to the child they give birth to. To become a mother, or give birth to one’s child, are social processes as much as biological ones.

liminality, as most of my participants felt in ‘limbo’ between being pregnant and non-pregnant women. In most cases, this may be ascribed to a lack of confirmation of their pregnancy, other than their initial pregnancy test(s):

*I’m quite tempted to do another [pregnancy test]. Just because of this, **you’re kind of in this limbo period until the scan, you don’t really know**, like I said, you know, it’s just, maybe psychological, so, it is quite tempting.*
Leila, 30-34, 11 weeks pregnant. Emphasis added.

An important component of this “limbo period” was the absence of any visible bodily signs of a pregnancy. Nash’s work on body image during pregnancy found that for her interviewees, looking pregnant was essential for them to be able to feel pregnant (2012b: 312). In what she calls the ‘in-between’ phase of pregnancy, Nash notes a disparity between participants’ internal and external experiences. Her participants imagined that they would ‘feel’ pregnant only as their bodies began to ‘look pregnant’. My participants voiced similar sentiments, as we shall see in Chapter Five. They described not feeling pregnant because there were no recognisable outward signs of a pregnancy, and speculated that they would feel pregnant once they started to get a bump (Gail) or feel movements (Beth). It seems then that outward and recognisable signs of pregnancy were important to my participants to feel pregnant. During early pregnancy, the women I spoke with were thus placed in a state of ambiguity both by the absence of generally recognised signs of pregnancy, and their tentative approaches to their pregnancies.

4.4.2 “Two realities”

The experience of being ‘in limbo’ suspended participants between being non-pregnant and pregnant women. This mirrors Rothman’s description of the tentative pregnancy, the central theme of this chapter, whereby a “pregnancy is medically acknowledged, made socially real, but the baby is not” (Rothman, 1988). Early pregnancy added a further layer to this ambiguity, where both the pregnancy was not yet (socially or for themselves) real, and a baby, even foetus, were imagined entities, for many not yet firmly present (even for those who had had early scans). Despite this, participants engaged in efforts to ‘do’ pregnancy (Neiterman, 2012). These included altering their dietary habits in accordance with medical advice, reading

pregnancy books and looking at pictorial representations of the foetus. As we have seen, they also largely kept their pregnancies a secret from others, prompted by the tentativeness they experienced due to the risk of miscarriage at this stage.

Participants thereby articulated a sense of inhabiting two worlds, one where they were pregnant, and one where they were not. This was described by Gail. Notably however, she implies that though tentativeness will reduce after twelve weeks, it will nevertheless remain:

*“[After twelve weeks] the risk’s gone down massively...so you can just be like right I’m going to plan for it, I’m going to tell people, and it’s that whole, **not trying to hold the two realities in your head anymore**, just being able to kind of go this is it, it’s probably happening, but like, really probably, rather than, possibly.*

Gail, 35-39, 11 weeks pregnant. Emphasis added

This sense of inhabiting two realities during early pregnancy was a strong theme throughout my early interviews. We have seen already the two realities inhabited in the sense of participants’ emotional reaction to their pregnancies, whereby they balanced the excitement of being pregnant, with acknowledgement that it may not go on to be successful. Engaging with the ‘twelve week rule’ by refraining from sharing news of the pregnancy with others, in line with this emotion work, also reflected this. As Simmel explains in his examination of secrets: “secrecy secures the possibility of a second world, alongside the obvious world” (1906: 462). Women occupied one reality in which they were pregnant, when with partners or those who also knew about the pregnancy, and one where they remained non-pregnant women. For many the latter was mobilised on nights out with friends or in the workplace. These experiences were again referred to by one participant as being “in limbo”:

It does feel a bit like a limbo, yeah, cos you’re also trying not to think too much about the future because, if something was to go wrong, you don’t want to have created too many of those, sort of thoughts, but um, yeah you start, you start to think a little bit more and more as time goes on.

Heather, 30-34, 11 weeks pregnant

Though I had expected her not to, due to her very tentative acceptance of her pregnancy in response to a history of recurrent miscarriage, Andrea also considered a

second ‘reality’ whereby she has a successful pregnancy. Due to the frank nature of our discussion during this first interview, whereby she explained her awareness that pregnancy “doesn’t always turn into a baby”, I had expected Andrea to be engaging in particularly stringent emotion work to prevent thoughts of a future baby. Her experience however, surprised me:

Emily: I don’t think you are, I think your answer’s no, have you thought about the rest of your pregnancy? Like can you see yourself being second, third trimester?

Andrea: Do you know it’s strange, and this is why it’s really difficult, you can’t stop yourself. I don’t want to, but then at the same time, like it’s so nice... you kind of feel like it’s gonna make things worse, if it goes wrong. But at the same time, it’s really nice to think about it.

Andrea, 30-34, 9 weeks pregnant

We see here that Andrea found it difficult not to think of a future successful pregnancy, even though this was at odds with the emotion work she was undertaking to prepare herself for a possible pregnancy loss. Another challenge to women’s efforts to minimise their investment into a successful pregnancy was presented by their interactions with medical professionals. The booking appointment, which for my participants took place at between eight and ten weeks (see Appendix I), involves an assessment of (medically defined) risk to the pregnancy, deduced from a detailed medical history, and information about women’s relationships and health related behaviours. Information is also gained from women about their knowledge of breastfeeding and other post-birth activities. The appointment, which for most interviewees lasted for around one and a half hours, also involved the provision of reading materials, and a ‘Bounty pack’: an information folder containing advice and free samples related to pregnancy. For some participants, who, as discussed had been trying not to think beyond the risky first trimester of pregnancy, the booking appointment thus could conflict with their efforts to maintain an emotional distance from the idea of a future baby:

She said ‘have you heard about skin-to-skin contact?’, so I was like, vaguely but, not really because up ‘til like a few weeks ago, I was just kind of like, thirty five year old just going through life really, erm, I didn’t have to think

about this kind of stuff so. And at the moment I still don't think I have to think about this kind of stuff, because I'm still just like 'once I get to twelve weeks, get to twelve weeks'.

Marisa, 35-39, 9 weeks pregnant

After arranging an appointment with her GP before her sixth week of pregnancy, and being given the impression that she had presented too early, Sinead was surprised that issues related to later pregnancy and birth were broached at the booking appointment:

I was really surprised to get [the Bounty pack]. I thought, it does seem, it does seem a bit too soon to sort of, that they sort of say 'caution', but then they give you stretchmark cream in a bag.

Sinead, 25-29, 11 weeks pregnant

Andrea's experience of having several miscarriages resulted in her feeling apprehensive about her coming booking appointment. Having been to one for her previous pregnancy, she felt that it was too early for her to receive literature on breastfeeding when for her there was a chance that she could still miscarry. For her, the notion that she would be breastfeeding seemed very remote. Even within the sphere of a setting commonly associated with risk, it therefore remained necessary for women to undertake emotion work, and balance these "two realities".

4.5 Conclusion

This chapter has aimed to capture the uncertainty experienced by my participants, women pregnant for the first time, in early gestation. This was largely due to their awareness of the risk of miscarriage during the first trimester of pregnancy. This awareness came not only from medical sources, but also understandings of foetal development, and empathetic experiential knowledge. Women thus engaged reflexively with the medical information on miscarriage they received, judging it to be credible based on their experiential knowledge (Wynne, 1992). In light of this perceived threat to their pregnancies, and uncertainty as to whether they would be affected by a pregnancy loss, interviewees' narratives echoed the experience of the 'tentative pregnancy' described by Rothman (1988).

In the context of the tentativeness experienced, participants engaged in what Hochschild (1979) has termed ‘emotion work’, which included the suppression of positive thoughts about the pregnancy, a resistance to thinking too far into the future, and also refraining from telling wider friends and family about the pregnancy. This represented the ‘twelve week rule’ regarding secrecy during early pregnancy, known to pregnant women through its promotion in pregnancy resources, but also anticipated and expected of them by others. My respondents engaged in this to prevent having to tell others about a pregnancy loss should this occur – which was interpreted to be a significant threat - but also in line with their emotion work to stem thoughts of a successful pregnancy. My participants’ narratives have thus contributed to an appreciation of the enactment of the tentative pregnancy, which has as yet been under-explored.

Interviewees’ actions in this regard provided understanding of women’s experiences of early pregnancy as ambiguous or ‘liminal’, and the requirement for participants to manage “two realities” (Gail). We also observed the challenges to women’s attempts to this, for example to maintaining secrecy, and those posed to their emotion work. The latter at times came from an unlikely source: health professionals located in a sphere usually associated with the promulgation of discourses of risk. Despite the potential for anxiety entailed in medical care (Rothman, 1988; Lupton, 1999b), women appreciated the contact they had with medical professionals, articulating instead that this provided reassurance. As such they often sought as much information as possible, and lamented the lack of initial contact they experienced with the medical institution. Health professionals however, often did not acknowledge the emotion work that interviewees were undertaking, and could pose challenges to this.

This chapter has also emphasised the importance of considering gestational time in discussions of the experience of risk. As we shall further observe, early pregnancy marked a distinct period for participants when seen in the context of the nine months of gestation. As well as the depiction of the first trimester as the ‘riskiest’, imposed

by women and medical discourse, it was also marked for many by the absence of foetus, both in terms of women's embodied experiences, and because it had not yet been visualised. The next chapter will discuss the emergence of the foetus, which during early and mid-pregnancy was accessible only through its representation.

Chapter Five

The Emergence of the Foetus

5.1 Introduction

As discussed in the literature review, images and imaginings of the foetus are prominent in contemporary British culture. Existing literature has documented the emergence of the foetus as an independent subject through technologies such as ultrasound (Petchesky, 1987), with the ascription of personhood demonstrated in the treatment of foetuses as patients (Casper, 1998), and as a result of the practices of pregnant women and their families (Han, 2009b). However, the understanding of the foetus as an independent subject was far from the experiences described by many during the earlier stages of their pregnancies. This chapter therefore responds to recent work interrogating the stability of unborn entities (Lupton, 2013b). Lupton explains that pregnant women themselves often hold ambivalent or shifting conceptualisations of the unborn (2013b: 118), and this was evident in the accounts given by my interviewees. I argue that for my participants, contributing to this was the fact that in the absence of recognisable foetal movements, which are said to be first felt at around seventeen or eighteen weeks (NHS Health Scotland, 2012), women's experiences of the foetus were created only through its visual and aural representation.

The data presented below first outline participants' experiences of the foetus during the very early weeks of their pregnancy. I then move on to explore three technologies or artefacts available to women during pregnancy in Scotland, which contributed to creating a foetal presence for participants. These were the visual depictions of foetal development available in books and online, the ultrasound scan, and the foetal heartbeat Doppler machine. The data presented largely draw on women's experiences prior to their twenty week scan, though experiences from later

pregnancy are drawn on at times. As we shall see below, for many this period was a time when the foetus remained ambiguous. I hope to demonstrate that in order to try and grasp women's thoughts and feelings regarding the foetal entity, it is important to pay attention to the contexts in which these take place; gestational time, understandings of development and perceptions of risk are some of the factors at play. I hope to move away then from a singular understanding of the foetus, exposed in the literature introduced above. I propose that discussions of the unborn in the social sciences should occur through women's experiences of them, in order to highlight the fluidity and elusiveness of foetal entities. Prior to the sensation of foetal movements, these experiences could only be constituted through medically and technologically derived representations of the foetus

5.2 Representation and scientific practice

As part of the sociological study of scientific knowledge and practices, scholars have described the mechanisms through which scientists come to establish and transmit scientific facts (e.g. Latour and Woolgar, 1986; Shapin et al., 1985). One aspect of this has been to interrogate the representational forms used in scientific practice. As introduced in Chapter Two, within scientific (and medical) practice, visual forms of representation are particularly valued. Indeed, Fyfe and Law (1988: 3) explain that depictions are integral to scientific production, demonstrated by the extensive employment of graphs, images and diagrams in the transmission of scientific knowledge. When applied to individuals, imaging technologies are particularly compelling, claiming to make the 'natural' visible, and shaping how we conceptualise health and the body (Treichler et al., 1998; Burri and Dumit, 2008).

For Latour, the power of such representations rests in the fact that they are "immutable mobiles" (1986: 7): complex phenomena are reduced to simplified figures, which may then be seen and shared without distortion, allowing for the original objects to be discarded. This is evident in medicine, for example, where technologies such as the thermometer or electrocardiogram transform symptoms into numerical and pictorial evidence, thus dispensing with the need to refer to a patient's body or doctor's assessment. Such devices have historically been considered more

valuable. Dispensing with an individual's subjectivity, they have thus been perceived to be more objective (Rice, 2013). This accords with a general privileging of visual knowledge in western culture, whereby the information gathered through visualisation is regarded as autonomous and pure, and thus blurs the boundaries between seeing and knowing (Jenks, 1995).

Social scientists and humanities scholars however, have pointed to the act of seeing as a *social* practice. This is not least due to the role of the self in visualisation. Merleau-Ponty's (1962) seminal work exploring the phenomenology of perception, including through hearing and touch, demonstrates that to perceive is not a passive internalisation of external stimuli. It is in fact an active process, conditioned, for example, by perspective or memory, and also subject to historical and cultural convention (see also Amman and Knorr Cetina, 1988). Further still, what is accessible to visualisation within the context of scientific knowledge is also open to interrogation. Graphical displays and other representations are not simply neutral reflections of objects of study, but produced within specific contexts and for specific purposes, and subsequently disseminated in line with these considerations (Lynch and Woolgar, 1990). More recently, scholars have called for attention to senses other than sight in the production and dissemination of scientific knowledge, highlighting the use of sound in measurement (Jackson, 2012), laboratory talk (Amman and Knorr Cetina, 1988), and the role of sound in the development of modern medical practice, in the form of the stethoscope (Sterne, 2003).

This chapter aims to demonstrate how the foetus came to be experienced by the women interviewed during the stage of pregnancy prior to the sensation of foetal movements. At this time, the foetus was only accessible through its visual and aural representation¹³. I interrogate some of the work that went into these practices of representation, which are reliant upon not only the materiality of women's bodies, but the technologies available, and also social relationships and exchanges. These representations contributed to cementing the presence of a foetus as a reality for some participants. However, because these representations are embedded in the

¹³ Resonating with the 'cyborg' or 'techno' foetus (Casper, 1998, Franklin, 2006), discussed in Chapter Two.

contexts in which they were created and consumed, they also had the potential to add to the ambiguity of the foetal entity.

5.3 The foetus(es) in early pregnancy: abstractness, absence, and aliens

Despite the great deal of literature documenting the propulsion of the foetus into contemporary public consciousness, less has exclusively considered conceptualisations of the foetus held by women themselves. Exceptions to this largely relate to the ultrasound scan, discussed further below. Schmied and Lupton (2001) and Lupton (2013), also engage with women's accounts of the foetus. In line with my aim to demonstrate the diversity of experience over the course of the nine months of pregnancy, I will show that the foetus as discussed by much of the existing literature was not a feature of my participants' *early* experiences of pregnancy. As noted in the preceding chapter, talk of a concrete entity referred to as a foetus or baby was rare during the first three months of gestation. Though these *terms* were invoked at our first interview, they were rarely used in reference to the notion of a fixed and certain materiality currently within them. As we observed, many interviewees instead referred to the abstractness of pregnancy (see Section 4.4), and thus for many the notion of a foetus within did not seem real. For example, Beth had received a Babygro as a Christmas present from her mother, at which time she was ten weeks pregnant. In accordance with her efforts to not get 'too excited', she was cross at having received this because she wanted to stay "realistic" about the pregnancy. Thinking about the Babygro during our first interview, she explained:

I opened it and it just was like, yeah, it just, the connection between being pregnant and then having, it didn't match yet, if that makes sense... it's still a little bit removed. So you know, it's strange, you do know it's happening and it's happening within you. But it[']s just not quite real yet.

Beth, 35-39, 11 weeks pregnant

For others, there was again doubt as to whether there was even a foetal entity within them during the first few weeks of pregnancy, and for some this remained by the time of our first interview:

I just hope it's there, and it's like, yeah. And it's not just, I dunno, too many pies or something.

Gail, 35-39, 10 weeks pregnant

For Felicity, an emergency scan at six weeks (discussed further below) changed how she perceived her pregnancy. The uncertainty she voiced prior to this was due to her mother's experience of very early pregnancy losses, and thus her knowledge that a positive pregnancy test did not necessarily signal the presence of a foetus:

Up until that time, you don't even know if there's like, a viable foetus in there, like my mum had quite a few, erm, things called blighted ovums, so basically there was no viable foetus, from the word go really. So I was worried that that could be the case.

Felicity, 25-29, 10 weeks pregnant

For those who did articulate the presence of an entity inside them, there was ambiguity in how this was referred to, and perhaps conceptualised, by my participants. In lieu of having a tangible and knowable entity to refer to, interviewees discussed the foetus in varying ways, including through their use of words used to refer to children, but also references to non-human beings. Though some women used the term 'baby' during our first interview, this was also interspersed with reference to a foetus, a non-human (e.g. the term 'alien' was used by five participants in our first interview, and by all but one over the course of the research), or again references to the absence of such an entity. This is evident in Deborah's narrative below:

*But **the kid** is like this big [approximates size of foetus with thumb and forefinger], you know, I just don't understand how it could possibly need that much...I feel like it's so small, like, come on, how much could it possibly need, just like stuffing **this monster**, that keeps crying out for more food.*

Deborah, 35-39, 12 weeks pregnant. Emphasis added

Some participants invoked biomedical terms in their descriptions of what was happening inside them, hinting perhaps to the extent to which medical framings of pregnancy had shaped their experience. For example, some interviewees used the terms 'blastocyst' or 'embryo'. However, this was largely in relation to descriptions of development provided to me by my participants, as opposed to directly referring

to the entity within them. In our first interview Eve discussed her recognition of a foetal presence in terms of an “egg”. Her conceptualisation of the foetus I felt elegantly captured the experiences articulated by many of my interviewees, though only Eve referred to it using this term:

I think of it more as like an egg. And like, something more, like, that doesn't really have human characteristics yet...I think when it starts to have, more defined features, I'll think of it more as like, a full person. Whereas, yeah, I guess the thing I think most to describe it is like an egg, where it's just, yeah there is life in there, but it's not like, defined yet.

Eve, 25-29, 9 weeks pregnant

Gerber (2002), who conducted interviews with French women regarding their experiences of the drug RU486 for medical abortion, found that participants referred to what they expelled as ‘the egg’ (‘l’oeuf’). According to Gerber, the women’s use of a term representing unfertilised material, whilst simultaneously acknowledging their pregnant state, encapsulated the ambiguity of early pregnancy. Most importantly for my analysis, she asserts that use of the term ‘egg’ represented her participants’ understanding of their place on a reproductive continuum, whereby pregnancy is conceptualised as a process entailing a series of discrete events (2002: 96). According to Gerber, her participants’ use of the term ‘egg’ aided recognition that they were ending the pregnancy early, when the entity within them was viewed as distinct from that which would exist further along the process. This was salient for the women she interviewed, who felt it preferable to abort early, rather than later in pregnancy. Although a very different context, dealing with planned, rather than the unwanted pregnancies in Gerber’s work, my participants also used ambiguous terminology in our initial interview. This I suggest, relates to their experience of early pregnancy as tentative, and the emotion work undertaken by women, discussed in the previous chapter.

Any conversations about a ‘baby’ during my first interviews with participants were largely in terms of an imagined and future being, not the entity currently within

them¹⁴. Like Gerber's work, my participants also seemed to discuss a reproductive continuum, whereby it was articulated that the entity within them may (hopefully) *become* a baby during or after the nine months of pregnancy, but had not yet achieved that status. Early discussion of the foetus within them seemed to point to my participants viewing it as a potentiality, rather than a knowable entity. This was best demonstrated by Nancy. She explained how she would react should she have a similar experience to a friend, who at her first scan found that she had "two yolk sacs", indicating the presence of twins, but only one surviving foetus:

I think if that were the case for me I would just be like well, you know, it's not, it wasn't, it wasn't a baby, it was a, um, it was a collection of cells that had the potential to be a baby...it's a bit like, if I had a lottery ticket but I didn't know what the numbers were, if I then accidentally ate that lottery ticket, I wouldn't be sad for like, 'oh I miss that bit of paper, I really loved that bit of paper'. I'd be sad for, that could be something great and now it's not gonna be...So [laughs], but it's not because of, oh that bit of paper meant a lot to me, or whatever. No, it's what, the chance the bit of paper represented.
Nancy, 25-29, 11 weeks pregnant

Both Nancy and Beth discussed that the upsetting thing about such an event would be that the (tentative) dreams and plans they had been making would have to be re-thought, or put on hold. These feelings echo the voices of women in existing research, who had experienced a miscarriage during the first trimester of pregnancy. Some of these participants articulated their miscarriage in terms of a 'loss of possibility', both in terms of the foetus and their own futures (Frost et al., 2007).

I was surprised that Nancy, and three other of my participants, discussed the potential loss of a pregnancy in this straightforward manner. This was perhaps because of my expectation that interviewees would feel pressured to ascribe to conventions of 'good motherhood' during pregnancy (described in Chapter Two) in the presence of an unknown interviewer, an expectation that Gail and Sinead subtly acknowledge in the quotes below. My surprise was also perhaps due to the fact that I

¹⁴ This was also implied in discussions of the advice regarding substances to avoid eating or drinking during pregnancy. Most participants did not describe avoiding these at this stage in terms of harming the entity currently within them, but in terms of the 'guilt' or blame they would feel should, as Ingrid put it, "something be wrong with the child".

had begun my research having read various scholars' emotive stories of pregnancy loss (e.g. Letherby, 1993; Layne, 2003). Such accounts have described a strong sense of loss and grief felt by women experiencing miscarriage. Diverging from these, during discussions of a *potential* pregnancy loss in early pregnancy, two of my participants, Gail during the recorded interview, and Deborah after the recorder was switched off (detailed in my field notes), explained that should the pregnancy end at the point of their first scan, their concern would be that they had gone through the difficult first trimester of sickness for nothing, and would potentially have to go through it again:

If I went to the scan and they were like 'oh it's not viable' or whatever, I wouldn't be, it sounds really selfish but, I wouldn't be grieving for a baby, I'd be pissed off about the three months of feeling crap that I've gone through... it's not really like losing it, it's kind of like it never was. Because it was never right in the first place if you lose it that early. It was, yeah, it's almost a bit like a failed attempt at conceiving.

Gail, 35-39, 10 weeks pregnant

The notion of a 'failed attempt to conceive', indicates, like Eve's notion of an 'egg' that a miscarriage would not involve the loss of an established 'baby' or even foetus, but a potentiality, representing a discrete event at the beginning of pregnancy, which may have *become* either of these (cf. Frost et al (2007)). In the case of miscarriage, Gail saw that this potentiality was in some way not meant to progress along, or even on to, the reproductive continuum. Sinead discussed her feelings towards a potential pregnancy loss in terms of what she labelled 'bonding', and speculated that her feelings regarding a pregnancy loss would change as the pregnancy continued, again drawing on the notion that the entity within her would *become* something to 'bond' with:

Emily: To be pregnant, in the beginning...there's so much, you know, all this discourse of risk

Sinead: Well, the risk isn't to you necessarily though. It's to the, foetus. So in a way, I know that sounds, I know that doesn't sound at all maternal, but um, you can kind of, you're gonna be OK. I know that sounds awful...Maybe it's

something to do with bonding with the, as it obviously grows and you get more aware of it, you, you become more concerned for its safety.
Sinead, 25-29, 11 weeks pregnant¹⁵

The minority of participants who spoke in this way contrasted with participants such as Keira, who did not articulate such sentiments. Keira said many times that she hoped her coming twelve week scan showed healthy foetal development, seen in her quote below. I noted however, that here, Keira also refers to losing an “idea” rather than the pregnancy itself or a foetal entity:

[I’m] mainly excited, yeah, erm, I think, the only little bit of me is just thinking oh, I hope there’s nothing wrong...as time goes, has gone on, I’ve gotten more used to the idea, and sort of know I’d find it hard if there was something, not right.
Keira, 30-34, 12 weeks pregnant

By contrasting these participants, I do not wish to assert that Keira was more emotionally or otherwise committed to her pregnancy than the preceding participants. I am instead highlighting the different experiences and contexts giving rise to women’s varying conceptualisations of the foetal entity within them. Experiences of conception, for example, provide the background to the above assertions regarding the possibility of miscarriage; Gail and Deborah had found it very easy to become pregnant, and voiced the feelings below in their discussion of a possible miscarriage;

Every time I feel bad [i.e. anxious] [my husband]’s like, ‘we got it on the first try Deborah. If something happens we can do it again’. So at least like there’s a lot of reassurance in that...if something happened then we at least, we have all the right bits to try it again.
Deborah, 35-39, 12 weeks pregnant

It is of course important to take these accounts of miscarriage as speculative, and not stemming from actual experience¹⁶. Nevertheless, the experiences related above

¹⁵ I noted that though she had referred to a baby a handful of times in the interview, when discussing a potential loss Sinead began using ‘foetus’. Though this may not have been purposeful, I did not notice as dramatic a switch in language in other participants’ narratives. As discussed, various terms were often used interchangeably. Even in the case of Sinead and Gail, though they seemed to be talking about similar experiences and entities, Gail refers to a ‘failed attempt to conceive’, whilst Sinead refers to a ‘foetus’.

indicate the elusive nature of the foetal entity during early pregnancy, conceptualised in different ways by different women, and at different times. The fluidity of the foetus has previously been discussed in social science literature, though this has largely been in relation to the practices of health professionals. Williams et al (2001) for example, demonstrate how ‘the’ foetus may be variously constructed as a person, patient, ‘nobody’ or commodity by different groups of practitioners within the same hospital. Casper’s (1994) research has also pointed to the contingent nature of foetal positions in the contrasting domains of foetal surgery and foetal tissue research. I would argue, however, that in these cases, ‘a’ foetus is present, physically engaged with on a regular basis by the health professionals in question, and onto which these various constructions can be imposed.

For my participants, and other women during very early pregnancy, this is a period largely characterised by the lack of a physical or embodied representation of the foetus. As such, a foetal entity largely exists only in the imagination, shaped variously by the many artefacts engaged with by women to construct the as yet invisible foetus into something tangible (discussed below). Unlike for the health professionals discussed by Williams et al (2001) and Casper (1994), then, it could therefore be seen that multiple representations of the foetus were engaged with by each of the individual women I interviewed during early pregnancy, experienced differently according to their exposure to obstetric technologies and perception of risk to the pregnancy, among other factors. By recognising the fluidity of the foetus as experienced by women in early pregnancy, we create room for more nuanced understandings of pregnancy loss and maternal-foetal ‘bonding’, but also for decisions to proceed with an abortion. According to Kimport (2012), these are generally reduced to simplistic discussions of attachment versus non-attachment, and corresponding feelings of regret versus relief.

¹⁶ The one participant in my research who had experienced miscarriage, multiple times, did not discuss the possibility of another in the same way (though did take comfort from the fact that despite her negative experiences, she had been able to conceive relatively easily).

5.4 Appearance(s) of *the* foetus¹⁷

As we have seen above, most of the participants in my research discussed foetal entities as something abstract, non-human and even absent in early pregnancy. Yet, in their narratives many expected such feelings to change as the pregnancy progressed:

Maybe sort of after the scan it will feel a bit more like that that's definitely happening inside cos it's, you can see it. And maybe, maybe when you can feel it, and maybe when you start to get a bump, they all must start to make it feel more real.

Heather, 30-34, 11 weeks pregnant

Here, Heather looks to the future, and speculates on the artefacts and events that will change her current experience of pregnancy, which she indicates is 'unreal'. Her quote, however, does not touch on an important artefact used by all of my participants, including Heather, to help grasp the reality of their pregnancy: timelines of foetal development.

Franklin (2007) notes that medico-scientific discussions of the foetus place an emphasis on development. She asserts that a fascination with the foetus' linear growth leads to an emphasis on what the foetus will *become*, inescapably entailing reference to the foetus' potential personhood. Anti-abortion groups have harnessed this 'teleological' version of the natural facts of pregnancy, writes Franklin, to argue that 'life begins at conception'. However, pro-choice campaigners also draw on the developmental potential of foetuses, for example in terms of the future consequences of genetic anomalies. These examples demonstrate how particular constructions of foetal personhood have come to shape the parameters of current debates regarding abortion (2007: 199). As indicated, at times my participants also discussed their pregnancies in terms of teleology. However, for some of my participants, the ambiguity with which they described the foetus in early pregnancy indicated that it was not certain to become a future baby. Early pregnancy seemed a discrete event for some, whereby the foetus may go on to secure a place on the reproductive

¹⁷ When I discuss the appearance of the foetus I refer to the material entity, and not to the appearance of foetal personhood, which is a different matter, and for me not automatically entailed.

continuum, but may be lost; in which case they would have to start again. I argue that this was shaped by their experience of early pregnancy as tentative.

5.4.1 Representations of development

As the weeks progressed, many of my interviewees began to feel more confident that the pregnancy, and foetus, had become established. As such, I heard more discussion of the future changes that would occur to their bodies and the entity within them. The latter was aided by diagrams of foetal development. These were available in pregnancy booklets provided by healthcare professionals, ‘popular’ books such as *What to Expect When You’re Expecting* (Murkoff and Mazel, 2009), and on the websites discussed in the preceding chapter e.g. *babycentre.co.uk*. These resources often take the form of weekly diagrams depicting the appearance of the foetus at each of these stages (using drawings, foetal photography or computerised images) alongside a description of its development.

In the absence of recurrent visual or embodied evidence of the presence of a foetus in early pregnancy, all of my participants regularly looked to these depictions for information about what was happening inside them. Indeed, the majority had elected to receive these weekly via email, which many could also access on their mobile phones. These helped my participants to begin to imagine a foetal presence:

It was ten weeks last week...he’s able to bend his elbows but his hands, you know, his fingers are still bent. And um, little, pads are forming for where the nails, fingernails’ll go and stuff. You know, so wee things like that just makes it, makes it a wee bit more real.

Beth, 35-39, 11 weeks pregnant

Keira described how the notion that the foetus was increasing in size, as well as knowledge of specific developmental events, helped her to think about an emerging ‘person’. She nevertheless ends this extract not by thinking of a ‘foetus’ or ‘baby’, but an inanimate object:

I’ve been like using a, the BBC like um, pregnancy calendar as well, um, I’ve kind of pictured each bit, because it’s quite cool to like, like for instance this

[twelfth] week apparently like, we're getting fingernails, which is quite cool. So I can kind of picture it kind of changing, and becoming more of a person. And the size and stuff, erm, and I kind of just imagine, I dunno, a little balloon getting bigger or something.

Keira, 30-34, 12 weeks pregnant

Some of my participants reserved their reading of the updates as a weekly ritual for themselves and their partners, though many read ahead to the following week or beyond. Julia had sought out a resource providing daily updates of the foetus' development. Participants therefore seemed to take pleasure from their use of these regular depictions of the foetus. Some conceptualised these as providing specific details of the foetus within *them*. Indeed, Julia explained, before correcting herself, that:

[The updates] give you a picture of your baby. Well not your baby, but what it's supposed to look like, and what developmental stage it's in

Julia, 25-29, 10 weeks pregnant

It is important to note that the images and descriptions to which women gave so much weight, with some taking them as prescriptive account of what was happening within and to their bodies, have a specific history. Modern understandings of prenatal development owe much to the use of both morphological (descriptive) and experimental (physiological) approaches in the life sciences (Clarke, 1987). The former is represented by embryo collecting, whereby embryos and foetuses were collected and preserved to assist in mapping embryological development (Morgan, 2009). The second key resource behind the developmental diagrams with which pregnant women are today so familiar is the use of animals in experimental science. Clarke (1987) explains that the wider shift within the reproductive sciences from a morphological to an experimental approach necessitated that scientists had access to live specimens, and as such were required to use animals including swine and cattle to further their knowledge of the (human) embryo. Findings from animal specimens were thus presumed eligible to 'transpose' (Friese and Clarke, 2012) to the bodies of humans. Animal models still feature in embryology today, with images of animal embryos presented interchangeably alongside human embryos in medical textbooks (e.g. Carlson, 2009; Schoenwolf and Larsen, 2009).

We see then that the view of prenatal development held today, as a sequential series of stages producing “amoral biological entities” (Morgan, 2009: 12) rests on a great deal of assumptions, opportunities and networks of both human and non-human actors. Such work is black-boxed in women’s engagement with the weekly updates consulted on their mobile phones, and shared with their partner in the regular rituals described to me by participants.

5.4.2 Foetus’s first picture – the ultrasound scan

Another artefact of representation experienced by women during pregnancy is of course the ultrasound scan. This is perhaps the artefact most widely discussed by social scientists considering prenatal technologies, with numerous book-length accounts, articles and ethnographies available (e.g. Mitchell, 2001; Taylor, 2008; Han, 2009b; Roberts, 2012). As discussed in Chapter Two, technologies of visualisation are often portrayed as a key contributor to understandings of the foetus as already a person. Indeed, Mitchell (2001) has labelled the images produced by ultrasound as ‘baby’s first picture’. Since scholars began discussing the obstetric ultrasound scan following its adoption as routine in the late 1980s, the technology used, settings from which ultrasound scans are available, and the point of gestation at which women encounter them, have changed significantly.

Existing literature regarding the ultrasound scan often discusses the experiences of routine scans, offered after the first trimester of pregnancy. These authors describe such scans with reference to the facilitation of ‘bonding’, inscribed into the technology and its environment, for example, with the inclusion of a swivel-screen allowing women to see the monitor, and chairs for family members to also view the image (Taylor, 1998). This demonstrates the co-production of women’s experiences of emotional attachment to the foetus, and how this experience has in turn shaped the technology available. In the UK, some (private) companies now offer ‘bonding scans’ during the later stages of pregnancy, often in 4D, which feature large screens, music, and the provision of a DVD. These are distinguished from routine scans

provided by the NHS - ‘bonding scans’ may not include any clinical measurements and tests (Roberts, 2011).

In addition to the scans described above, three participants in this research received a scan before their ninth week of pregnancy¹⁸. For Felicity and Sinead, this was due to suffering a small amount of bleeding. Andrea’s was due to her history of miscarriage. The early (before twelve weeks) scans undergone by three participants in this research were experienced very differently from those described above. For two participants, these took place at short notice, on recommendation from their GP. Scans took place at an Early Pregnancy Assessment Unit (EPAU). Whereas in the context of a routine scan participants described being able to see the image immediately, on a fixed, large screen directly in front of them, at the EPAU the sonographer consulted a small screen initially hidden from women’s view (though this was turned around to allow women to see following the sonographer’s examination). Here then, rather than facilitating a connection or attachment to the foetus represented in the image, the environment instead seemed to encourage women to ‘prepare for the worst’, again invoking the association of early pregnancy with miscarriage, discussed in the previous chapter.

Sinead described her experience of an early scan, late in her sixth week of pregnancy, as one of feeling like a “subject”, due to her husband being able to see the screen, whereas she could not. This is a contrast from routine scans where women (and their companions) are provided full view of the screen, and talked through the image by the sonographer:

There was a little sort of bean shape with a, the sac, and you could see that, and the heartbeat, so that was quite nice, that was nice to see. Although they didn’t, I was just the subject sort of thing, my husband was sort of, able to look at the whole thing and sort of see the, the sort of flashing thing.

Sinead, 25-29, 11 weeks pregnant

¹⁸ Criteria for an ultrasound scan with the NHS prior to the first routine scan include lower abdominal pain, vaginal bleeding, poor obstetric history and estimation of gestational age (Abdallah et al, 2011). These can also be purchased privately.

Here, except perhaps heartbeat, Sinead uses no language to signal that she was viewing a foetus or ‘baby’, often demonstrated in existing literature regarding the ultrasound scan. At this stage the foetus, according to Felicity, was a mere five millimetres long (she explained there was “nothing really there”), and as such it would be hard to interpret. It is then perhaps no surprise that, in contrast to existing literature and my participants’ experiences of later scans, despite having had the presence of a foetus confirmed, these three participants retained ambiguous feelings about the reality of the pregnancy:

I mean, it is really, hard to believe to be honest, like I just can’t picture it inside me just now, I just don’t feel like, you know, there’s anything in there really other than, feeling sick all the time.

Felicity, 25-29, 10 weeks pregnant

This is despite Felicity having seen the scan at six weeks, which earlier in the interview she described as having “reduced her concerns”, due to her worry that her family history might make her susceptible to blighted ova. For Felicity, and Andrea too, I would argue that this ambiguity was in part due to the sense of risk that they keenly felt to the pregnancy at this stage. As Andrea explained:

Although it’s reassuring, to see that it was alive at seven weeks four days, [it] doesn’t mean. Yeah. I’ll be happier when we get to the twelve week scan...an early scan at seven weeks four days is really nice, but you know you’ve still got another massive hurdle to go over.

Andrea, 30-34, 9 weeks pregnant

These participants’ experiences thus highlighted the contextual nature of the knowledge provided by ultrasound at this stage of the pregnancy. The twelve week scan was seen by participants to provide reassurance, and signal that they could share news of the pregnancy with others. This was due to it coinciding with the twelve week threshold onto which they placed so much emphasis. Yet, these early scans were interpreted as merely reporting that these interviewees were pregnant, and the foetus was alive, *at the time of the scan*. As such their feelings about the reality of the pregnancy and its future remained ambiguous.

5.4.2.1 *The tentative pregnancy*

Prior to their initial blood tests and routine scans, participants were provided with a booklet detailing the screening tests on offer to them as part of their NHS care. This gave details of the purpose of the scans, and highlighted that the scan is not always a happy experience. It also informs women that they are able to choose whether or not to have an ultrasound scan (NHS Health Scotland, 2014: 10). My interviewees had discussed these initial blood tests and scans with their partners before they reached twelve weeks gestation. However, in line with the tentative approach to early pregnancy discussed in the preceding chapter, the women I spoke with seemed not to have thought beyond these initial tests:

We both felt that uh, we would like the screening tests that were available at this stage, and depending on what the results were, to those tests, we'd then have to think again about what happens next...But there's no point quite thinking about that quite yet.

Keira, 30-34, 12 weeks pregnant

We still hadn't had really much of a discussion about what we were gonna do if we did find out that there was something wrong with it. But we both went 'OK, well we'll jump off that bridge when we get to it'.

Marisa, 35-39, 19 weeks pregnant

We see then that again, temporal conceptualisations of the progression of pregnancy projected by health services and women themselves could conflict, with women thinking in terms of short term 'milestones', and the information they were given looking further to the future, and prompting women to think beyond twelve weeks.

In accordance with the sense of risk to the pregnancy described in the preceding chapter, all but two of my participants (Ingrid and Julia), described feelings of apprehension - though in varying degrees - before and during their twelve week scan. Authors have described ultrasound scans as blurring the boundaries between diagnostic tool and entertainment (Taylor, 1998; Mitchell, 2001), and my participants' understandings of the scan as both were evident in their narratives, though emphasised at different times. Prior to the procedure, interviewees in my

research seemed very aware of the medical purpose of the scan they were to undergo¹⁹, and remained mindful of the fact that they may not receive positive news:

Obviously they're looking to check everything's OK and, it might not be.
Heather, 30-34, 20 weeks pregnant

I got myself in a wee bit of a tizz over [the 12 week scan], erm, well, just anxious...partly because I was starting to feel, good, erm, I hadn't had any sickness, my energy was coming back...I just thought oh here, something's happened.

Beth, 35-39, 19 weeks pregnant

The terrible thing is, when you're getting the scan, there's a...kind of ominous silence, you would think they'd be like 'so, I'm just looking and I think I see the head', and you know, but they're just [poker face]. And you're thinking, is that a good silence? Or a bad silence?

Nancy, 25-29, 19 weeks pregnant

These extracts demonstrate the tentativeness present in anticipation of, and during, the twelve week scan. Most participants though, like Heather, also described being simultaneously excited. The same mix of emotions has also been reported in previous research (Harpel, 2008). Ingrid was the only participant to express no sense of anxiety. She was instead impatient for the scan, which would allow her to tell others about the pregnancy. Her extract does not seem to account for the possibility of foetal abnormality:

That's when you find out that everything's fine with the child... but overall it's just knowing that everything I've done so far is fine. I just wanna, I just want it over and done with, just over and done and then just be able I guess to tell people as well.

Ingrid, 30-34, 12 weeks pregnant

Nevertheless, she does position herself as responsible for the health of the pregnancy. Due to the apprehension described beforehand, participants therefore articulated a sense of 'relief' when the scan indicated a healthy foetus (which was fortunately the case for all of my interviewees). Beth, after her twelve week scan, explained that she

¹⁹ This awareness was maintained throughout pregnancy, signalled by the storing of the printed scan images in their blue pregnancy folder, containing medical information administered by midwives.

felt “a big rush of ‘thank goodness’”, and Leila described each positive comment during the scan as “waves of relief”.

5.4.2.2 Making it ‘real’?

Han asserts that ultrasound replaces imaginings of the foetus with ‘real’ images of the foetus (2009b: 276), and as such it is often an event at which women accept the reality of the pregnancy (see also Georges, 1996). This seemed the case for many of my participants when encountering their twelve week scan:

It made it a bit more real. Like, oh, there’s actually a baby [laughs]. Because, up until then you don’t really, feel anything, except for like all these weird symptoms.

Julia, 25-29, 19 weeks pregnant

In line with existing literature (e.g. Mitchell, 2001; Han, 2008), participants described their scans in terms of the seemingly purposeful actions of the foetus. Interviewees began referring to a ‘baby’, now having a specific entity to refer to, and described the foetus’ actions such as ‘waving’ (Beth), ‘flipping over’ (Nancy) and ‘shaking and bouncing’ (Ingrid). Participants also described family resemblances, seen by themselves or by relatives, for example Caroline explained that she “immediately decided it looks like my uncle”. A comment by Heather’s mother made her laugh, but also signals the varying interpretations that can be drawn from a single image:

When we showed my mum the scan photo, the first thing she said was it looks like my husband. I was like, how can you tell? It looks like a prawn, you know it doesn’t even look, it was really funny.

Heather, 30-34, 20 weeks pregnant

I will not offer any more discussions such as this, as a great deal of literature has discussed women’s experiences of the ultrasound scan in these terms, and how their interpretations of the image, aided by the commentary of the sonographer, have contributed to understandings of the foetus as person and family member (Mitchell and Georges, 1998; Han, 2008; Taylor, 2008). Instead, as we see above with

Heather's quote, I will describe how the scan could also expose the ambiguity of the foetal entity. This was particularly true for Julia. Her scan was scheduled for fourteen weeks, as a forthcoming trip abroad would prevent her from attending at twelve weeks. In line with the feelings discussed in the previous chapter, particularly the fact that a scan would enable her to share her news with others, Julia was disappointed that her scan would not be at twelve weeks. Whilst away she discovered that she could undergo a private scan for a modest cost (compared to the UK), and as such purchased one at twelve weeks. Unlike routine NHS scans, this twelve week scan comprised a 4D element:

The face looked very [laughs] a bit strange, because it's not, everything is not in the exact position it's supposed to be, it's a bit alien like [laughs] ...I think the ears are not in the right position, and the eyes aren't in the right position either, they shift later on. By now everything's in the right position.
Julia, 25-29, 19 weeks pregnant

While signalling the reality of the pregnancy, Julia's scan simultaneously pointed to the ambiguous position occupied by the foetal entity, no longer mere cells, nor a *fully formed* foetus. Use of this technology for early routine scans may help to attend to feminist concerns, discussed in Chapter Two, which highlight the role of ultrasound and visualising the foetus in the creation of foetal citizens, against which pregnant women's rights are often opposed (Petchesky, 1987; Rothman, 1988). However, it is uncertain that women themselves would welcome such a change. Many of my participants sought images that looked like a 'baby'. For example, Deborah was glad not to have received a scan earlier than twelve weeks, because she would not have wanted to see the foetus as an "olive", without limbs. Following her twelve week scan, Leila hoped the twenty week scan would look more human-like:

It's got a really big head, head's really out of proportion. So that's one thing I'm kind of hoping Friday['s scan] will be a bit more in proportion, I'm not worrying just, it's just odd you know. Alien baby in there.
Leila, 30-34, 19 weeks pregnant

This is also indicated in Julia's declaration that "by now everything's in the right position", signalling to me (and perhaps herself), that the foetus will now have the

appearance of a baby. Such considerations thus complicate feminist arguments, which seek to resist the personification of the foetus. Julie Roberts' recent work (2012) highlights this issue. She asks how feminist theory, which often points to the potential for ultrasound technology to constrain women's reproductive freedoms (e.g. Zechmeister, 2001), can account for the pleasure women gain from this technology. Roberts asserts that perhaps one way to disrupt the potential constraints posed to women's choices may be to consider responses to ultrasound other than those which personify the foetus, some of which were demonstrated by participants in this research. This is elaborated upon further in Chapter Seven.

Like Julia, above, many found that their pregnancy was made real by the ultrasound scan. Nevertheless, for a minority of participants, and in contrast to the vast majority of existing literature, it seemed that the twelve week scan could contribute to the abstractness of the pregnancy:

I didn't make the mental connection between what was going on here, and what was on the screen there...it was like I was watching a television programme...[I] can't get round the concept of it being inside me.

Marisa, 35-39, 19 weeks pregnant

It's quite funny cos...it's like, that is in there, but it doesn't, compute you know...It's like, how can somebody bouncing around inside you like that, going mental, and you don't feel it?...it is bizarre, trying to make that connection.

Beth, 35-39, 19 weeks pregnant

Like Beth, Caroline also described the disconnection between the image on the screen and her embodied experience, after visiting the toilet midway through her scan:

I was in the loo and I had this weird feeling that the baby was still on the screen, like I'd left it, behind, it wasn't, I had this kind of feeling of I should, you know, like it's still in the room, and I'm here, and I'm gonna go back to it [laughs]

Caroline, 35-39, 19 weeks pregnant

She explained that she had to tell herself "no, what you saw is actually what's...in you, and not there". That the scan can affect a sense of detachment from the notion

of a foetus *within* their bodies challenges the majority of existing literature. Some work, however, describes the purposeful harnessing of the technology to exact this very phenomenon.

Teman's (2010) ethnography of gestational surrogacy describes the methods employed by surrogates to suspend the formation of an emotional bond with the foetus they carried. This was seen to be an instinctive attachment by some surrogates, which they had previously experienced during pregnancies with their 'own' children (2010: 38). Part of this suspension of bonds entailed the conceptualisation of the womb as a neutral space, stripped of personal traits and spatially separated from the rest of the body. A similar experience is signalled in Caroline's account, above. The women in Teman's study purposefully used the ultrasound scan to aid their distancing practices, for example by imagining the womb as a disembodied organ, or by symbolically looking away from the image during the procedure (2010: 78). Beynon-Jones' (2014) recent research, with women undergoing scans before abortion, has further pointed to the potential of the scan to de-personify the foetus. Her participants pointed to their interpretation of the scan solely as a diagnostic procedure, and also were more focused on the "science" and "intrigue" of the experience, in contrast to some of the experiences described in existing literature. The scan has also been discussed in terms of allowing stronger connections between the foetus and those other than the pregnant woman, including commissioning couples in surrogacy (Roberts, 1998), and expectant fathers, while simultaneously minimising women's "special relationship" with the foetus (Sandelowski, 1994: 231).

Perhaps this disembodied experience of the foetus during the ultrasound scan has been enabled by the fact that foetal images are now ubiquitous in contemporary UK culture. As Morgan suggests, "the distinction between real fetuses, models, and computer-generated inventions is repeatedly and deliberately fudged" (Morgan, 2011). Several participants described looking at ultrasound videos posted by other women online prior to their own scan. This familiarity with such images may

therefore result in a difficulty for some women in identifying the image viewed at the scan as being within *them*.

For those who did describe the scan as providing proof of the reality of pregnancy, among some there was a sense that while the ultrasound scan may have shown them at the time that they were pregnant, there was a sense that the reality attained was only temporary:

I was gonna say it didn't really seem like there was a baby in there until [the scan], but it still doesn't seem like there's a baby in there so, not really. I mean I'm, you know, I'm convinced, they showed me, but that's about all.

Gail, 35-39, 19 weeks pregnant

Some participants explained that this sense of unreality, despite the scan, was due to (a lack of) their embodied experience of pregnancy. This was the case for Beth, who found it difficult to “make the connection” due the fact that she could see the foetus moving at her twelve week scan, but not feel it. For those whose pregnancy sickness and other symptoms began to wane following the scan, there was once again no obvious sign of a pregnancy. As we have seen, the ‘temporary’ nature of the information provided by the scan was most obviously articulated by those who had undergone scans at between six and nine weeks pregnant, largely due to the sense of heightened risk surrounding their pregnancies at this time. We see then that the context in which the scan takes place, including the presence of embodied experiences of gestation, and interviewees’ sense of risk to the pregnancy, shaped women’s interpretations of the image.

Another element of the twelve week scan with the potential to change women’s experiences of pregnancy was its subsequent announcement to wider family and friends. As experienced by grandparents-to-be receiving news of the pregnancy in existing research, articulation of the news meant that for friends and family a future pregnancy became a tangible experience (Cunningham-Burley, 1986), which in turn altered experiences for a small number of my interviewees. For Marisa, telling others made her feel more supported, because her and her partner were “not in it alone now”. For Keira and Heather, telling others added to a sense of reality with

regards the pregnancy, as people begin to talk about the pregnancy and ask questions. Heather explained “it kind of makes you feel like you’re definitely doing it”. For Beth, this also entailed negative consequences. She noted that since finding out about the pregnancy, other women had “revelled” in telling her their “horror stories” of pregnancy and birth.

For some, telling others also re-centred the tentativeness they had felt prior to twelve weeks. Andrea, who had shared the news before twelve weeks with more people than with her previous pregnancies, explained that she remained hesitant, and felt “uncomfortable talking about it...like I shouldn’t have told people”. We have already observed in the previous chapter that Marisa and Deborah waited a further two weeks following their scan before telling others. Even then, Deborah’s anxieties regarding the pregnancy remained:

As soon as like my colleagues started knowing and stuff, I, I did have a slight wave of panic that, is this gonna be a very public thing if something goes wrong?

Deborah, 35-39, 19 weeks pregnant

This was almost the case for Nancy, who immediately after her twelve week scan posted news of the pregnancy on her Facebook page. In what she described to be a very distressing experience, the following morning she began bleeding heavily, and feared a miscarriage. She explained:

After the twelve week scan, the day after when I started bleeding I was just like, this is so unfair, I was told this was like the line that you crossed and then you were safe, and suddenly I crossed that line and actually someone was like ‘oh we’re joking, the line’s over there’ ...actually it’s not safe yet.

Nancy, 25-29, 19 weeks pregnant

Nancy’s experience, and that of Andrea, Marisa and Deborah, demonstrated the dissonance between the fixedness of the first trimester threshold as described in the literature provided to women, and women’s lived experience. Most of my participants’ experiences of early pregnancy were shaped according to the twelve week threshold. However, Andrea, Marisa and Deborah’s uses of the ‘twelve week

rule' reflected their understanding that despite having passed the first trimester, tentativeness remained, and was liable to reappear throughout gestation.

5.4.2.3 *The strategic use of ultrasound technology*

Julia's decision to pay to acquire a scan at twelve weeks, despite already being scheduled for one in an NHS setting two weeks later, demonstrates again the strength of some participants' observance of the biomedical thresholds and procedures imposed upon pregnancy at this stage of gestation (Simonds, 2002) (though as we shall see in the following chapter, engagement with these became more fluid as the pregnancy progressed). Caroline was offered a scan, prior to twelve weeks, whilst working abroad during early pregnancy. This was despite attending for a suspected urinary tract infection. After being directed to the gynaecology department due to the fact that she was pregnant, she was offered a scan free of charge. She deliberated before deciding not to accept this:

*I really don't want one because I've got one scheduled for when I get back, it's like, you know, **we don't usually have it 'til twelve weeks...**like I'm on my own here...**I can't really do it without my partner**, that would be a bit unfair and, also you know, **if something was wrong then what am I gonna do?** I'm on my own here. Um, so I, I kind of said no, thank you very much.*
Caroline, 35-39, 19 weeks pregnant. Emphasis added.

Here, Caroline refuses a scan for several reasons. She acknowledges the medical purpose of the scan, to "check that everything's OK", and like Julia ascribes to the allotted time frames for such appointments, imposed by the medically based schedule of NHS antenatal care. She also, as discussed in the previous chapter, prepares herself for the worst, recognising the possibility that the scan may not deliver good news, and as such does not want to have to face this alone. However, she simultaneously frames the scan as an important *social* event, requiring her partner's attendance, pointing once more to the hybrid nature of the ultrasound scan (Taylor, 1998).

Caroline thus does not refuse the technology itself (and its purpose), but the context in which it is offered, both in terms of timing, and due to the absence of her partner,

for whom she suggested that the scan was also an important occasion (this is attested to by Draper's exploration of male partners' experiences of ultrasound (Draper, 2002)). Caroline's approach to the technologies and surveillance offered by medicine resonates with Lock and Kauferts' volume exploring the pragmatism of women in the face of reproductive technologies (1998b), countering the portrayal of women as passive subjects of medicalization processes implicit in early feminist accounts (described in Chapter Two). Unlike many of the situations explored in Lock and Kauferts' collection though, this was not a matter of resistance (though this was a feature of later pregnancy for some, see following chapter). As we have seen, the previous chapter demonstrated that women largely welcomed medical intervention at this early stage of pregnancy. Participants' engagement with technologies was more akin to the pragmatism outlined by Lock and Kaufert. This resonates with the notion of 'tactics' described by de Certeau, who conceptualises cultural products, such as technologies, in terms of a "repertory with which users carry out operations of their own" (1984: 31).

A similar, strategic, approach was observed in the way participants interacted with ultrasound technology later in pregnancy. Like their twelve week scan, all participants attended their foetal anomaly scan at around twenty weeks gestation (see Appendix VII). Again, some participants articulated being nervous before this procedure, with Felicity acknowledging that "they're gonna take measurements of things, that potentially they could find something [wrong]." This scan differed visually from the twelve week scan due to the larger size of the foetus. As such, more detail could be observed, with participants recalling features including the stomach, kidneys and the individual chambers of the heart. For some this signalled that the foetus was closer to becoming a 'baby':

Even at your twelve week scan...you can see the head and stuff, but it's still kind of a foetus...but by twenty weeks it's definitely getting there.

Leila, 30-34, 19 weeks pregnant

The foetus nevertheless still occupied an ambiguous position for several participants, who felt that the presentation of images in this scan, which at times were displayed in

cross-section, or ‘slices’, and included minute detail (for example when focusing on the lens of the eye) made the foetus appear “alien” (Gail) or “ghostly” (Heather). For some like Leila, who had begun to feel movements at the time of their second routine scan, it was easier to associate the images produced by this scan as something happening within their bodies.

One aspect of the twenty week scan, through which participants demonstrated a pragmatic use of the technology available to them, was the opportunity to find out the sex of the foetus. The six participants who wanted this information were required to request this from the sonographer at the beginning of the appointment. Those who did not were told by the sonographer to look away from the screen at a certain point, as due to the larger size of the foetus, this information was assumed to be easy to interpret. This seemingly simple engagement with the technology, i.e. a strategic looking or non-looking, was in fact highly deliberated over by women and their partners²⁰. While some planned to keep this as a ‘surprise’, others such as Ingrid and Felicity wanted this information in order to further cement the reality of the pregnancy, and the presence of a future baby, which they now felt more comfortable reflecting upon:

I think again it'll help it seem more real, and erm, just help me to kind of come to terms with having, whichever it's gonna be. Help with choosing names and things as well.

Felicity, 25-29, 19 weeks pregnant

From my interviews it became clear that participants did not simply vary in whether they wanted to attribute personhood to the foetus, but the *degree* to which they did this. For example, though as described above, many participants were keen to see images of the foetus resembling a ‘baby’, in both the ultrasound scan and illustrated representations, not all wanted to find out the sex²¹. Leila wanted information about the sex of the foetus, but described in our first interview that she did not want to know *too much* information:

²⁰ Four women reported that their partner had wanted this information, in order to foster a connection with the foetus, but that they did not.

²¹ Many liked an element of ‘guessing’, discussed later in this chapter.

...otherwise I might start giving, you know, a little person, a personality and haircut...I just kind of want them to be there and, learn about them when they're here, rather than make them into something they're not before they arrive.

Leila, 30-34, 11 weeks pregnant

That the majority of participants resisted the attribution of 'too much' personhood was most obvious in discussions of the use of 4D scans in later pregnancy, which could be obtained from private clinics. Two participants purchased these because they allowed for the visualisation of the foetus' face, seemingly seen as an important piece of knowledge to conceptualise a baby. This was true for Ingrid who wanted to "put a face to the name" that she had picked. Nancy had been bought a 4D scan as a birthday present from her husband at twenty eight weeks, and was to receive another 4D scan at thirty six weeks, paid for with medical expenses from her employer (again, a clear demonstration of the hybridity (Taylor, 1998) of ultrasound technology):

[The sonographer said at twenty eight weeks] you might not be able to see like whether, like for us whether baby's gonna have like, kind of African...cos my husband's got very pronounced lips...So, em, this time might be able to see whether he's, turning into a little mini George [husband] or mini Nancy.

Nancy, 25-29, 33 weeks pregnant

Here, Nancy discusses gaining knowledge of the foetus in terms of kinship, signified here by family resemblance. 4D technology offered Nancy an additional means of constructing the foetus as a person, through the clear visualisation of a human face, but also as 'her baby', by indicating its visual similarity to her and/or her husband (also discussed by Roberts, 2012). The notion of family resemblance demonstrates the relational aspect of kinship, and has been described as a mode of constructing family bonds (Marre and Bestard, 2009). By the time we met for our last interview, Nancy did articulate a sense of the foetus as family member. Though Ingrid and Nancy sought out 4D ultrasound technology, and the opportunities for creating personhood and kinship bonds it offered, the majority of participants rejected 4D scans, with Leila saying that they were "too surreal" and "too much", and Sinead calling them "unnecessary".

5.4.2.4 Producing the image

We have seen that participants experienced their ultrasound scans in different ways, and in different contexts. The creation of the image by the technology was a collaborative project; ultrasound technology did not merely reflect the foetus within, but produced it, in conjunction with sonographers, and women themselves. Prior to their appointments, for example, my participants were asked to fill their bladder by drinking water (with the necessity of this decreasing as the foetus gets bigger). This is in order to ‘push the uterus up’, allowing the sonographer to get a ‘better picture’ (NHS Health Scotland, 2012). Women’s actions in this regard therefore influenced what could be visualised using the ultrasound technology. The position of the foetus also dictates the image produced. Three participants, including Keira, said that they had taken the request to fill their bladder “too literally”, to the extent that the foetus had been “squashed” and the sonographer was unable to take measurements. In this situation, or when the foetus was simply in an inconvenient position for the sonographer, women were asked to empty their bladder, move position (for example, Felicity was asked to “go into a crab position on the bed and wiggle around”), or to return after having a sugary drink. For three participants, some clinical measurements were unable to be taken during their twelve week scan. These women were required to return for an additional scan a week later, in order to attain a Nuchal Translucency measurement to assess Down’s syndrome risk. What is seen by women is also often subject to the sonographer’s verbal interpretations of the image on screen, or how they ‘show’ the baby (Mitchell, 2001). For interviewees, though the head and torso were sometimes visible, or as Gail explained, “obvious”, body parts such as the feet and hands were frequently, and selectively, pointed out by the sonographer.

Adding an additional tier to these considerations, Meyers (2010) points to the interactions between the ultrasound machine’s vibrations and tissues and cells, which are variously shaped and reshaped by each other, thus attending to the active role a woman’s body, at a minute level, plays in creating the image. Meyers calls for the ‘re-inscription’ of women’s bodies into foetal images. One means of achieving this

may be through exposing the networks involved in the production of the visual image. These include the history of the ultrasound scan's development, a process which itself comprised complex strategies and decision-making (Yoxen, 1987). Further, attention to the interactions undergone during the procedure, between individuals and at a molecular level, may assist in reconceptualising ultrasound technology as embodied, thus visually re-placing women as the subjects of their pregnancies.

This section has shown that though many participants at times spoke of ultrasound similarly to existing literature, which often emphasises ultrasound's potential for 'bonding' (Taylor, 2008), for some the technology also contributed to the ambiguity of the both foetus and its position within women's bodies. It seems that when women's experiences of the scan are considered in terms of a discrete procedure, detached from much of the wider context of women's pregnancies (an approach taken by many of the existing accounts of ultrasound), the scan does provide evidence of the reality of pregnancy, and can provide reassurance regarding the health of the foetus. However, when seen as one of the many events and experiences of gestation, the status of the knowledge provided by the scan is less certain. It was also interpreted by participants in terms of embodied experience, and with regards to levels of risk perceived to the pregnancy. These shifted over the course of gestation. Participants largely voiced awareness that the images they received were a representation, providing information about the foetus *at a specific point in time*. As we shall see in the following chapter, when experienced later in the pregnancy, in the context of evident embodied knowledge, the information provided by the scan was often devalued. First, I will turn to another notable technology experienced by women during pregnancy, the heartbeat Doppler machine.

5.4.3 Hearing the foetus

All of the women I spoke to during my research had experienced the handheld Doppler ultrasound machine, though like the scan, in different ways and at different times. Health professionals, often midwives, use this device to detect and monitor a foetal heartbeat. The machine amplifies the sound of the foetal heart, which is then

fed to a speaker, enabling not only the midwife but also those in the room to hear the heartbeat. The equipment may also display a reading of the foetal heartbeat in beats per minute (bpm) (Jezewski et al., 2006), thus reducing this aural experience to a single number – an ‘immutable mobile’ (Latour, 1986).

Whilst the visual is often privileged in the production of medical and scientific knowledge, as observed in the introduction to this chapter, scholars have begun to address the role of sound in scientific practice (Pinch and Bijsterveld, 2004). Like vision, the way in which individuals listen, and what they listen to, can be intentional and discriminatory, and is representative of wider social and cultural norms and changes (Bull and Back, 2003). The Doppler machine, just one means of accessing the foetal heartbeat, embodies the extensive monitoring of the foetus (Lupton, 2012), through its assessment of foetal health in terms of bpm. It also demonstrates the contemporary re-configuration of the technology by users, through the transposition of the Doppler machine to non-medical settings, discussed further below.

Nine of my interviewees first heard the foetal heartbeat at their second midwife appointment, at around sixteen weeks gestation, and all were able to listen to it at subsequent appointments. Though the majority enjoyed the experience of hearing the heartbeat, some also demonstrated the potential for this auditory technology to again create a disembodied, or externalised (Rice, 2008), experience of their pregnancy. For example, Gail, who had also discussed the inability of the scan to resolve the ambiguity of early pregnancy, explained:

[It was] weird...I mean, it was, it was good but it's even less easy to believe than the scan, cos, it's just a noise isn't it?

Gail, 35-39, 19 weeks pregnant

Andrea, who was particularly anxious about her pregnancy due to her previous miscarriages, felt similarly, finding it difficult to connect this sound with what was happening within her. This was despite being in her third trimester of pregnancy at the time:

I don't really think of it as my baby's heartbeat though, it's just like a weird noise that comes out of the sky.

Andrea, 30-34, 35 weeks pregnant

For the majority of participants, hearing the foetal heartbeat at sixteen weeks was described as a method of reassurance, as opposed to coming to know the foetus (more associated with the scan). Beth described it as another “milestone” she had successfully overcome, providing confirmation that the foetus was still there.

Heather also felt that hearing the heartbeat signalled foetal health:

Anything still could go wrong, and I'm kind of aware of that, but...when you've heard the heartbeat and things like that, you just sort of start to think OK it's, it's strong and it's, so far so good, it's been doing what it's supposed to be doing, so, why wouldn't it continue?

Heather, 30-34, 20 weeks pregnant

Once she had passed this milestone, Andrea was planning to buy maternity clothes, despite not having been able to do up her trouser buttons for a few weeks already. She said that hearing the heartbeat would confirm that “it's a baby and not fat” (despite already having had three scans).

However, as with the scan, the amount of reassurance provided, and value placed on the Doppler, seemed to be dependent on the temporal context of pregnancy. Gail experienced the Doppler later than others, due to her being unable to meet her midwife at sixteen weeks. She first heard the foetal heartbeat at eighteen and a half weeks, and explained that:

It would have been better at sixteen weeks, cos actually...I was only a week away from having the scan...so I was already kind of thinking I'm nearly gonna get the scan and see it again so, but if it had been properly at sixteen, it would have been more welcome.

Gail, 35-39, 19 weeks pregnant

Deborah was not offered the Doppler during her midwife appointment at sixteen weeks. She was upset about this because, despite having seen her twelve week scan, she did not feel pregnant between thirteen and sixteen weeks due to the waning of

her symptoms. However, she explained that she soon recovered from her disappointment at not hearing the heartbeat, as she began to feel foetal movements a week later. A discourse of pregnancy as tentative is once again implicit here, and shaped Gail and Deborah's experiences of the Doppler, seen by them, and others, as primarily an instrument of reassurance. As intimated earlier in this chapter, participants who were asked thus preferred the experience of the scan, which provided them with visual evidence including recognisable features such as hands, which many seemed to privilege. For example, Julia noted during our second interview that *seeing* the heartbeat on the scan negated her need to hear it.

A minority of participants seemed to express their experience of the heartbeat in terms of contributing to a sense of (potential) personhood. Heather explained that she felt "proud" on hearing the foetal heartbeat, and began to conceptualise the foetus as a future child by describing this as "a pride she would feel for the rest of her life". Three interviewees described the same "old wives' tale" whereby if the sound of the heartbeat was comparable to a horse galloping they would have a girl, but a sound like that of a train signalled a boy. Like ultrasound images (Mitchell, 2001, but also participants such as Heather, above), the product of the Doppler technology was thus amenable to appropriation by women themselves, who wanted to gain information about the foetus. This, however, occurred on their own terms: two of these three interviewees declined knowledge of the sex at their twenty week scan. Like the printed ultrasound images obtained by all interviewees, some participants fixed the temporary representation produced by the Doppler by recording the sound of the foetal heartbeat on their mobile phones, which was often then shared with others. Again, though the majority of my participants had mobile phones with this facility, only three described participating in this activity.

The technology used by midwives to hear the foetal heartbeat was also available to women outside of a medical context. The accessibility of such devices provides further insight into women's strategic engagement with the technologies available to them. Though relatively affordable (Sinead and Ingrid told me that they can be purchased for around £20-25), seen by the majority of participants to provide

reassurance, and widely available online, just two of the participants in this research used a Doppler machine themselves. Sinead explained that her initial thoughts about buying a Doppler were “a brief failure on [her] part”. Her explanation for not going on to purchase one seemed to be linked in part to a rejection of consumer culture (a part of her identity which surfaced during all of our interviews, with her calling the future baby “the second-hand kid”), but her explanation was largely centred around arguments regarding the reassurance it could provide:

What is it good for? Nothing. It's, well, I mean I s'pose they say it's peace of mind, but if it's kicking then you've got peace of mind I s'pose. Free peace of mind.

Sinead, 25-29, 19 weeks pregnant

I interpret Sinead's rejection of this technology as due to her having begun to feel foetal movement, discussed further in the following chapter. Because she had begun to experience this, she viewed the Doppler machine as unnecessary, also commenting on its monetary cost. For participants it seemed that (early) sensations of movement, and hearing a heartbeat were essentially providing the same information: confirmation of the presence of a live foetus. Sinead was later given a Doppler machine by a family member at around twenty four weeks pregnant, by which time she was regularly feeling the foetus. She used it only twice, once “for fun”, and once when she temporarily could not feel foetal movements, which she seemed to privilege as providing “peace of mind”.

I would like to turn briefly here to the *types* of movements experienced by participants. Later in gestation, as demonstrated by Sinead and discussed in the following chapter, foetal movements could provide women with privileged knowledge of the pregnancy. The *initial* movements experienced by all of my participants however, were uncertain. For example, on beginning to feel “light flutterings” when we met for our second interview at nineteen weeks, Leila exclaimed “it could just be like food digesting you know or wind or something”. Keira, Ingrid, Andrea and Felicity described similar experiences of being unable to distinguish sensations caused by the foetus and those arising from within their own bodies. Having never experienced pregnancy before, their interpretations of these

were moulded by the representations of foetal movements gained from descriptions in books, from their midwives, or the experiences of family and friends. Due to their uncertain status, my interviewees therefore distinguished these early sensations, which Eve declared were “not movements”, from the later ‘kicks’ they anticipated. These they looked forward to, inferring that they would provide them with reassurance of the wellbeing of the foetus, and safety of their pregnancy.

In the absence of certain bodily knowledge of a foetal presence during early pregnancy, one participant was keen to turn to auditory knowledge in advance of her first scan. Nancy, having used multiple (cardboard and digital) pregnancy tests to monitor the permanence of her pregnancy during the first eight weeks, purchased a Doppler machine during her ninth week of pregnancy. She described this as prompted by her husband’s dismay at the money she was spending on pregnancy tests. In contrast to Sinead, Nancy was eager to embrace not only the most up to date equipment for her pregnancy and the future baby, but also all of the medically-based technologies available to her, stating in our first interview that “any medical intervention [medical professionals] can offer me, yes I’ll take it”. Many commercially available machines differ from those used by midwives; they may feature (sometimes two) headphone sockets, the ability to record the heartbeat, and an absence of the LCD display showing bpm, thus inscribing a specific pattern of usage (non-clinical and related to notions of bonding) into the technology. Nancy explained during our first interview that on using the machine for the first time she initially discerned her own heartbeat, before moving the device to her pelvis in order to hear the heartbeat of the foetus, which she knew would be faster. From then on the technology served to assuage her concerns regarding pregnancy loss, providing her with the ability to check the foetal heartbeat for herself. Yet, recognising the potential for the machine to provoke, as well as to alleviate anxiety, she had rationed her usage, explaining that “otherwise I would have it on my head the whole time”.

Accordingly, Nancy’s use of this technology endowed her with the ability to ascertain foetal health in ways previously known only to healthcare professionals. At her sixteen week appointment, Nancy was initially refused use of the Doppler

machine due to its potential to cause anxiety, should the midwife not be able to detect a heartbeat at this stage (a reason given to other participants who were refused the Doppler at sixteen weeks). However, Nancy asked to use the midwife's machine herself and quickly found it. It seemed that Nancy felt more confident interpreting this aural information than that provided by the ultrasound scan, which she appreciated being talked through by the sonographer. As she explained: "I'm not a trained medical person or anything, but I know that's a heartbeat". Nancy's interpretation of the information generated by the Doppler, in which she played an important role, was dependent upon her attunement to the sounds of heartbeats (Rice, 2012), both hers and that of the foetus. She also suggests some previous tacit knowledge of these sounds, demonstrated by her negation of the need for medical training to appreciate their meaning.

Like ultrasound technology then, though accessible in various forms to all participants (to whom financial constraints did not pose a great barrier), they engaged with the technology of the Doppler machine in various, and strategic, ways. Again, gestational time, embodied experience and their attitudes towards technological intervention all shaped participants' engagement with Doppler technology.

5.5 Conclusion

Following the previous chapter, which outlined participants' tentative and liminal experiences of early pregnancy, here I have explored the ambiguity characterising women's experiences of a foetus within them. We have seen that for many participants there was a disconnect between the presence of a foetal entity and their experience. This was explained with reference to a lack of embodied evidence of a foetal presence, but also to the experience of pregnancy as tentative. Prior to the scan some speculated that they may never have carried a foetus, or that the foetus may have been lost.

Participants expected the reality of a foetal presence to be cemented as time progressed. Like medico-scientific understandings of foetal development, women

seemed to conceptualise the progression of the pregnancy in terms of linear and sequential stages, aided by visualising weekly diagrams of ‘a’ foetus, but interpreted by some as representing ‘their’ foetus. This chapter has outlined the work underlying these representations, which are in fact based on foetuses distinctly different from those carried by the pregnant women interpreting them as their own.

Unlike medical and scientific understandings of foetal development, those of the women I interviewed were shaped by their experience of early pregnancy as tentative. Accordingly, the foetus characterising the early period of pregnancy, if lost, seemed to be viewed as distinct from that which would go on to become a ‘baby’. Eve conceptualised it as an “egg”, Nancy as a ‘potentiality’, and Gail, should it be lost, would see the foetus as a “failed attempt to conceive”. As with the health professionals in existing literature, who perceived the foetus differently in accordance with its role in a medical setting (Williams et al, 2001), women also seemed to hold multiple conceptualisations of the foetus, even within the same context of carrying a wanted pregnancy. This approach, whereby the early foetus was viewed as a discrete entity, may have contributed to participants’ efforts to manage their emotions towards the pregnancy, in light of the reported high rates of miscarriage during early pregnancy.

For some, technological representations of the foetus within them prompted an acceptance of the reality of their pregnancy, the foetal entity, and a future baby with personhood, as discussed in existing literature. However, when we pay attention to the context in which each scan occurs, it is clear to see that further interpretations may ensue. For example, a first scan at twelve weeks had the potential to further add to the ambiguity of early pregnancy, due to the visual image, often moving, not according with embodied experience (at twelve weeks participants could not feel this movement). The fact that participants’ symptoms may have waned following this scan also could contribute to a sense that the scan was merely a temporary demonstration of a foetal presence. For example Deborah did not feel pregnant during weeks thirteen to sixteen, despite having had visual evidence of her pregnancy. Aural knowledge of the pregnancy too could contribute to both the

incomprehensibility of carrying a foetus, or to the ascription of personhood. The point in the pregnancy at which Doppler technology was used, and how this technology was applied, were important factors in how aural knowledge of the foetus was experienced.

Representations of the foetus obtained by women were determined by their strategic actions, with Caroline rejecting the opportunity to have an ultrasound scan, due to concerns outwith its medical purpose. Others declined some of the knowledge made accessible by ultrasound, for example regarding foetal sex. Some sought further information concerning the foetus than their standard antenatal care provided, for example Nancy was able to attain an estimation of birthweight at a (privately purchased) thirty six week scan. A great deal of interpretative flexibility (Pinch and Bijker, 1984) is therefore evident in women's engagement with the artefacts experienced during their antenatal care, not only through their differential use of these technologies, but also their different interpretations of the information provided.

As highlighted by science and technology studies theorists (e.g. Latour and Woolgar, 1986; Dumit, 2004), it is important to pay attention to the contexts in which these representations are created and displayed. This is not only true of illustrations such as diagrams of foetal development, into which their creator's interpretations are more obviously inscribed (Maienschein, 1991), but also of images produced by visualising technologies. These have historically been considered to be more objective, but this chapter has illustrated the work entailed in their production and interpretation. The foetus as experienced by women prior to the sensation of definite foetal movements was thus open to various reconstructions by women, interpreted according to perceived levels of risk to the pregnancy, and the point of gestational time at which these representations were engaged with.

By exploring the varying interpretations that may be made by women of foetal representations, this chapter has complicated existing literature that implicitly imbues ultrasound images, and aural knowledge of the foetus, with the power to cement the

reality of women's pregnancies. It adds to work such as that of Beynon-Jones' (2014). Her study of the use of ultrasound prior to abortion demonstrated that interrogating ultrasound outside of the setting of a 'low risk' and wanted pregnancy exposes hegemonic representations of the 'feeling rules' (Hochschild, 1979) of pregnancy and the procedure. She thus calls for an understanding of ultrasound technology as situated and malleable. However, as outlined above, *even in the case of wanted pregnancies*, the context in which these representations arose had the potential to construct foetal personhood, but could also further uncertainty with regards the entity inside them. Though theorists have asserted that ultrasound visualisation, and other technological forms of knowing the foetus, provide us with certainty, transforming the foetus from the "not-yet" here, to "an immune system in real time" (Duden, 1993), it seems this may not always be the case.

One (embodied) representation of the foetus that seemed to confirm not only its presence, but also its health for women, was the experience of definite foetal movements. This will be discussed in the next chapter. However, like representations produced by technological artefacts, sensations of foetal movements were not always straightforward to interpret.

Chapter Six

Embodied knowledge: towards a resolution of tentativeness

6.1 Introduction

This chapter, the final empirical chapter of my thesis, explores women's experiences of pregnancy from approximately twenty weeks onwards. For many of the participants in this research, this period marked a move towards the resolution of the tentativeness of early and mid-pregnancy. This was largely due to changed embodied experiences of the foetus within.

As observed in the previous two chapters, embodied experiences of pregnancy were initially ambiguous for the majority of women interviewed. Women were unsure as to whether they were feeling as they 'should' be in terms of sickness and their physically changing bodies, but also described their hesitancy to accept changing sensations in their bodies as definitively signalling the presence of a foetus. As the pregnancy progressed, women became more accustomed to the bodily changes they were experiencing, which became more measured and predictable, and added to certainty with regards foetal growth and movement.

The chapter will provide an account of the bodily changes experienced by my interviewees. For many these signalled foetal wellbeing, and thus contributed to easing tentativeness. I then link these changes to theoretical discussions of pregnant embodiment. I explore how embodied experiential knowledge, in conjunction with medical discourses pointing to the safety of the foetus, led to women feeling more 'relaxed', and for some, able to question some of the information they received from medical sources.

6.2 Becoming pregnant – the significance of embodied experiential knowledge

As described throughout this thesis, the experience of pregnancy shifted between the real and the abstract for my participants throughout approximately the first twenty weeks of gestation. This was variously attributed to the waning of symptoms such as nausea, the temporary nature of information provided by the medical technologies, and intermittent contact with medical professionals. This was constitutive of, and also provoked, the experience of early, and to a lesser extent mid-pregnancy, as particularly tentative. By the time I met interviewees for the final time, the experiences described to me were markedly different.

6.2.1 The growing bump

This section considers women's experiences of foetal growth. These were both visual and embodied, and as we shall see, complicated existing accounts of the pregnant body.

6.2.1.1 Maternity wear and foetal growth

An important part of feeling pregnant, and the elimination of ambiguity with regards women's pregnant status, was the emergence and growth of a 'bump'. As noted in previous chapters, in earlier stages of pregnancy women had already anticipated that this would signal the reality of their pregnancy. The emergence of the bump was a gradual process, which was reported by women to have accelerated between my meetings with them for our second and third interviews, taking place at approximately nineteen and thirty five weeks. All of my participants remarked that their bumps had been growing, with Marisa describing hers as "significantly larger" when we met for the third time. Because of this, all had purchased maternity clothes, which some had consciously avoided during earlier stages of the pregnancy. For Andrea, this initial avoidance was in part attributed to the tentativeness she felt about the pregnancy (and which she was still experiencing during our last interview),

I didn't want to [buy maternity clothes], until I, I'd had the [twenty week] scan. And I still haven't, and I won't get them 'til the [twenty week] scan

today. Because it just seems silly. Um, yeah so we haven't done anything like that. I do feel pregnant...but at the same time I go through phases where I don't feel pregnant at all. I still kind of am so worried that it's not gonna, turn into a baby.

Andrea, 30-34, 20 weeks pregnant

In an earlier interview at thirteen weeks, Andrea again asserted that it would be “silly” to buy maternity clothes, because she did not yet have a bump. At eleven weeks Julia also explained that she was waiting until later in the pregnancy to buy maternity wear, despite the fact that her trousers no longer fastened. She did not feel it was “worth it” to buy new clothes when we first met, opting instead to use an old hair-tie on her trouser button to extend the waistline. Sinead’s and Felicity’s reasons for limiting their purchase of maternity clothes related to concerns regarding the cost of these items. Similarly, Ingrid called the purchase of such items a “waste of money”, as they would only be worn for a short period of time. Echoing similar sentiments, others thus explained that rather than buying pregnancy-specific clothes, they instead began to wear more of their existing, less restrictive, clothes such as cardigans and long skirts. In addition, some, like Heather, told me that they were waiting to be loaned or given clothes by friends who had recently been pregnant.

By the time we met for our final interview, all of my participants had had to purchase at least maternity trousers²². Heather and Ingrid both explained, during their interviews at thirty five weeks pregnant, that they could *feel* that their bumps were growing. Ingrid explained that this must happen every two or three weeks, as she could also see a gradual difference in size. Keira acknowledged that her clothing had become more restrictive by the time we met at twenty weeks, and she thus accepted the need to purchase maternity wear. Heather and Sinead had even found that maternity clothes they had acquired a few weeks prior to our interview were no longer adequate. For many, the acceptance of the need for, and purchase of maternity clothes was symbolic of their bump growing, and of the pregnancy progressing:

I suddenly noticed that clothes rapidly stopped fitting...I had to over the course of the weekend just like go and buy more T shirts and vest tops and

²² These often feature a stretchy section of material to cover the bump, with the material able to expand as it grows.

things like that. I mean it was yeah, two weeks it went from being quite small bump to quite, probable, quite sizeable. So. Yeah, and that's when I really started to feel it kicking as well, so. I would say. Yeah, it all became very real.

Marisa, 35-39, 35 weeks pregnant

As described by Marisa, these embodied changes contributed to the reality of the pregnancy, aided by the simultaneous sensation of *definite* foetal movements, discussed in Section 6.2.2 below. In our final interviews, Sinead, Deborah and Eve explained that it was the specific *size* of the bump, not just its visible growth, which helped to cement the reality of the pregnancy. For example, Deborah had held a friend's newborn up in front of her abdomen. Observing that it was a similar size helped her to imagine a 'baby' within. Sinead also explained that in conjunction with the scans she had experienced, her bodily changes, which had begun to become more noticeable, had helped her and her husband to "believe" that they were having a baby:

Something about, having like, something about that size, and sort of, so we've both been a bit more, like we can...sort of, picture, you know, having an actual baby about that big...I think maybe it's something to do with the size of it, do you know what I mean, as well.

Sinead, 25-29, 33 weeks pregnant

It was not just the fact that their bump was growing in size, thus signalling a growing foetus, that allowed women to solve the ambiguity of their pregnant status. This could also be attributed to the fact that their bodies had taken on a pregnant shape, easily recognisable to them. Schutz (1953: 7) highlights that individuals' interpretations of the world are "based on a stock of previous experiences of it", our own or those communicated to us by others, which he terms 'common-sense knowledge'. My participants were very aware of the changes in body shape caused by pregnancy, not only due to having seen these changes in family and friends, but also due to the increased visibility of publicly pregnant bodies (Nash, 2006). As such, changes in their body shape, which would perhaps be alarming outwith the context of pregnancy, were expected and welcomed.

6.2.1.2 *Beyond control?*

Other signs of foetal growth were provided by the more unexpected bodily changes recounted by participants. These were experienced in addition to their visibly expanding abdomens, and for most, had not formed part of their common-sense knowledge of pregnancy. Deborah described that her expanding womb had caused her small intestine to move within her body, with her now feeling its “gurgles” in a different place, above her bump. A consequence of this movement of internal organs was that many participants were finding it difficult to eat entire meals, due to the fact that their stomach no longer had ‘enough room’. Nancy and Heather described that despite feeling hungry, they would feel full very quickly after eating, with Leila’s explanation for this being that her stomach “had been pushed into a weird shape”. This meant that participants had been forced to alter their eating habits, now eating little and often (reminiscent of the periods of nausea experienced in early pregnancy). For Leila, who at thirty five weeks found that when sitting down for a meal she could only eat half a plateful of food, this had consequences for the types of food she consumed. She found herself “grazing” on toast and cereal rather than eating “healthy meals”.

Felicity explained that changes such as this required “adjusting to”. Elements of their daily lives, such as their posture (Felicity), their walk (Julia) and their ability to walk moderate distances (Beth), climb stairs (Eve) or negotiate obstacles (Marisa was no longer able to climb over hedges and stiles for her site visits at work) had been altered by their transforming bodies. Most participants were not particularly affronted, however, by these changes to their lives in later pregnancy – which represented the most striking, in visual and size terms, of the whole nine months. In contrast to existing research (e.g. Longhurst, 2001; Warren and Brewis, 2004), the majority did not articulate that later pregnancy represented volatility or a loss of control over their bodies. Because these changes were largely expected, due to their common sense knowledge and extensive reading regarding pregnancy, the majority of women did not view them in the sense of being ‘beyond control’; a phrase implying unpredictability and unruliness (and implying that women ordinarily wield control over non-pregnant bodies (Warren and Brewis, 2004; Carter, 2010)). Eve

said that the changes at this stage were not as “dramatic” as in early pregnancy, and Andrea explained:

It's been going on for so long you kind of get used to it, you've watched your body changing...but you know what to expect because it's a gradual increase of what you were having a week ago.

Andrea, 30-34, 35 weeks pregnant

The changes that women were experiencing were thus largely described in terms of being measured or “gradual”. Indeed, Ingrid and Andrea both exclaimed that it was only when looking at pre-pregnancy photos of themselves that they really noticed the difference in their body shapes:

I think cos it's gradually growing I'm not paying attention...so yeah when I look back at pictures I think, now I think oh, I was tiny. But, I'm just used to it.

Ingrid, 30-34, 35 weeks pregnant

Existing research has demonstrated that the feelings held by women towards their pregnant bodies are dynamic and variable. Women's narratives may move between feeling in and out of control (Carter, 2010), and other work has shown that while some women may feel uncomfortable with the transgression of feminine ideals such as ‘slenderness’ (Bordo, 1993) represented by pregnancy (Johnson et al., 2004; Nash, 2012a), others may see pregnancy as an affirmation of their ‘womanhood’ (Bailey, 2001). Almost all of my participants commented that they had enjoyed pregnancy, and been ‘lucky’ in their experience. Many explained that they had expected to suffer from more of the unpleasant symptoms associated with pregnancy, such as swollen ankles. Like some of the participants in Bailey's (2001) work, two participants explained how pregnancy had provided them a new perspective on their bodies and their womanhood, with Eve explaining that she felt more “connected” to her body, and Heather asserting that:

It sort of starts to make you feel pretty proud as a woman, that, you have this amazing ability, um, to reproduce and, men don't, men's bodies don't change very much, throughout their lives.

Heather, 30-34, 35 weeks pregnant

Two participants provided exceptions to this generally positive assessment. Perhaps because of the active and outdoor nature of her work and leisure activities, Marisa commented on the negative aspects of her changed body, which had forced changes to her lifestyle:

I feel slightly kind of incapacitated at the fact that I kind of like, I walk upstairs and I feel knackered and out of breath, and I feel like it's starting to be a...bit of a burden. It's not that it's not enjoyable, but, it's for, the baby's now forcing me to kind of, modify my lifestyle quite a bit, I have to slow down, I'm getting tired, I have to have little kips, so, and I don't resent it but I just, it is impinging on my life quite a bit.²³

Marisa, 35-39, 35 weeks pregnant

Nancy was suffering from severe pelvic and back pain as a result of her pregnancy, which began during her twentieth week. As a result she was using crutches when we met at thirty three weeks gestation, and like Marisa had experienced pregnancy as limiting. She now had to use a commode at home due to her inability to climb the stairs to her bathroom. However, despite calling her pregnancy an “unmitigated disaster”, she later reflected on the value of having experienced pregnancy, enjoying the fact that she was able to feel the baby’s hiccups, and watch it move when in the bath (discussed further Section 6.2.2.2).

6.2.1.3 Getting the “body back”

Most participants had largely enjoyed the experience of pregnancy. They welcomed the changes they were experiencing, as these resolved some of the earlier ambiguity regarding their pregnant status. Nevertheless, all were keen to get their ‘bodies back’ following the birth. This is a common discourse among women experiencing pregnancy (Earle, 2003; Upton and Han, 2003; Dworkin and Wachs, 2004), and in existing research seems to be used in two senses; firstly as getting their bodies back to how they were physically prior to the pregnancy, and secondly as re-asserting

²³ Though it is notable here that she does not see that her body has forced these changes, but the growing foetus within her.

ownership over their bodies (i.e. back to themselves). My participants made use of both of these.

Drawing on the notion of wanting to return to their physical pre-pregnancy bodies, Julia said that she was looking forward to having her “flat tummy back” and sleeping on her tummy, whilst Beth wanted her “body back” because she was beginning to feel more tired in her pregnant body. Gail felt restricted by her pregnant body, being unable to go out for nice meals due to her small stomach, or to sit still in the cinema for two hours. Eve remarked that though she would miss being pregnant to some extent, she would have liked it to be shorter:

My friend...after she had the baby she was like ‘oh I’ve missed being pregnant so much’...But I’m doing this for the baby, I’m not doing this so that I have a bump for, like months and months...I’m doing it to have a baby not to be pregnant.

Eve, 25-29, 35 weeks pregnant

She explained that she had “not loved” being pregnant, and articulated a clear sense of pregnancy as being a temporary stage or step towards the ultimate goal of having a baby. Drawing on the second sense of getting her body back she explained:

I’m ready for when the baby comes, to be able to like separate my body from it. And uh, have my body back, I think. So er, as much as I do like having it, I’ll be happy to separate the two. It’s like, yeah it’s not, this isn’t like a permanent solution it’s, it’s a means to an end, I guess, it’s not how I want to be forever.

Eve, 25-29, 35 weeks pregnant

By using the phrase “have my body back”, Eve articulated a sense that she was sharing her body with something or someone else during the later stages of pregnancy, perhaps connected to her recognition that the foetus was now “his own being”. This is a departure from early pregnancy, where there was little sense of the presence of a foetal entity with which women shared their body. However, in an apparent contradiction, discussed in more detail in Section 6.2.3, she also explains that she is keen to “separate” her body from that of the foetus, implying that they are a unit.

Somewhat differently, Nancy and Julia's discussions focused on their embodied engagement with those around them. They articulated a sense of having been transformed into a 'vessel' for the foetus, with Julia describing that she had been "reduced to her middle":

People don't ask how you are, they usually ask, 'oh how's the baby doing?' I'm still here, I'm behind this big ball.

Julia, 25-29, 35 weeks pregnant

Because their pregnancy was visible to others, including friends and family but also strangers, those around them were able to interpret their pregnant bodies in ways which did not necessarily accord with how women saw themselves – perhaps here indicating a sense of the loss of control discussed in existing literature. In later gestation, other people began to comment on my participants' bodies and actions in ways they had not experienced prior to pregnancy. Nancy's narrative, below, was not typical of my respondents, but does accord with existing literature regarding the visibility of pregnant bodies (Longhurst, 1999):

I feel like a vessel for, for baby just now definitely...in terms of like the things that, a lot of what [my husband] and I talk about is things that I should be doing for the good of baby...like drinking Irn Bru [a carbonated soft drink], he's like, you know, you shouldn't be drinking that, it's got caffeine in it, which is not gonna be good for baby. So I feel like, my actions, aren't really up to me anymore, because I've got baby to, erm, protect. So it'll be nice eventually to just be like, you know what, yeah, as much Irn Bru as I can stomach and, as much paté as I can get hold of.

Nancy, 25-29, 33 weeks pregnant

Nancy's narrative indicates a clear sense of wanting her body 'back' to herself. Like Julia's experience, being visibly pregnant enabled others to appropriate women's bodies and give them meanings or advice that did not necessarily accord with the experiences of women themselves. As such, these two participants wanted to claim their bodies 'back' from those around them, as well as from the foetus with which they were sharing their bodies. Adding further complexity to these descriptions was the sense from some of my participants that they would be more restricted with

regards ownership over their bodies *following* the birth of the baby. Nancy for example later reflected that:

At the moment I don't really have to do anything to take care of the baby at all, I just need to eat... [Following the birth] I have to always know when to feed, and I'll, I'll respond to cues to feed, or, have to check the baby's bum all the time, or I'll have to like, check baby's breathing... Whereas now it's just like well, you know, I feel like a, I dunno, kangaroo or something, just stick in a pouch and forget.

Nancy, 25-29, 33 weeks pregnant

Heather also told me that whilst swimming, she had realised that it was one of the last times she would be able to be on her own. These sentiments reflected that birth does not necessarily entail the separation of my participants from the body currently within them, as in many ways they would remain entwined, for example through breastfeeding (which all of my participants planned to commence), and through a constant awareness of the baby's wellbeing. The experience of interembodiment with the body of another, then, was not seen by my interviewees to be unique to pregnancy (see section 6.2.3 for further discussion of this concept).

As discussed above, the growth of their bumps contributed to resolving the ambiguity that had earlier characterised women's experiences of pregnancy. Embodied experience in later pregnancy thus moved towards a resolution of their tentativeness with regards the success of the pregnancy. However, the public visibility of their pregnant bodies also had the potential to re-introduce the anxiety, and tentativeness, characteristic of early gestation. This was true especially for Andrea. As we have observed throughout this thesis, Andrea experienced her pregnancy as particularly tentative, which she had attributed to her previous experience of recurrent miscarriage. Andrea explained that since becoming visibly pregnant, she had begun to receive comments on the size of her bump from strangers, and that this had resulted in anxiety not only about her physical appearance, but also about the wellbeing of the foetus:

It's worrying because like, you've never, I've never been told I'm a big girl before...also, people don't realise actually, you're worried about the size of

the baby, so if people say you're really small, or really big, you think I'm not growing enough or growing too much...there was one woman in [the supermarket] who had a look of concern on her face, because, yeah she thought I was so big, carrying too much fluid, and suggested I go and get checked out

Andrea, 30-34, 35 weeks pregnant

The comments she received eventually prompted Andrea to begin lying about her due date, bringing it forward in time.

We have observed that the experience of the growing bump had the potential to resolve the ambiguity and tentativeness articulated by women in earlier interviews, demonstrated most clearly by Marisa, Eve and Deborah. This was because it provided evidence of the growth of the foetus, which was becoming 'baby-sized'. Additionally, echoing those participants in Nash's research, the growing bump was also a sign that their pregnancy was progressing 'normally' (Nash, 2012a), based on their common-sense knowledge. Yet, as Andrea explained, the visibility of these changes could in some cases act as a stimulus for others to comment on women's pregnancies, or provide advice. This could once again introduce feelings of uncertainty or anxiety regarding the condition of their pregnancy and the foetus²⁴. I shall now move on to what I glean to be the most important embodied experience in the move toward the resolution of the tentative pregnancy: the regular sensation of definite foetal movements. However, like the growth of their bumps, for some these also provided the opportunity for the re-introduction of tentativeness.

6.2.2 Foetal movements

As well as the physical presence and size of a bump, foetal movements were an important aspect of embodied experiential knowledge of pregnancy. As discussed in the previous chapter, initially these were not experienced clearly, characterised instead by a great deal of ambiguity. As such these early experiences were unable to resolve the tentativeness of earlier gestation, as they were not seen by women to provide reassurance of the pregnancy's progression. By the time I had met

²⁴ Though this was not the case for the majority of participants.

participants for our third interview, the sensation of foetal movements had changed dramatically since they had first been suspected. Though it has been argued that medical and technological knowledge have now overshadowed women's experiential knowledge of their pregnancies (Rothman, 1988, Duden 1992, 1993), my participants demonstrated that the sensation of *definite* foetal movements were an important and at times privileged source of not only knowledge of foetal wellbeing, but also a means of constructing the foetus as a (future) baby.

6.2.2.1 *Shifting sensations*

By the time I met with participants at between thirty three and thirty six weeks, they had experienced several changes in the sensation of foetal movements. In our final interview, I discussed the sensations described by participants at around nineteen weeks gestation. Reminding those who had felt them that when we met they had described them as uncertain 'flutterings' or similar, my participants would often exclaim that they were "definitely" movements now. Indeed, by the time of our third interview, these had changed from the "kicks" (Marisa) or "punches" (Leila) felt around mid-pregnancy, to "stretches" (Deborah), "squirming" (Beth) or "shifts" (Julia):

I've kind of, it went through that middle stage with being, like really, I don't wanna use the word violent²⁵, but really, quite, you know strong kicks, and you could see, and, it was very much hands and legs, you know, er feet, just actual small body part prods. Whereas now cos there's not as much space it's very much kind of, whole body movements, whole baby is shifting.

Leila, 30-34, 35 weeks pregnant

Such patterns of change in foetal movements have also been documented in existing research (Raynes-Greenow et al., 2013). For many, in harmony with their visibly changing bumps, this change in embodied experience provided a sign of there being "less room" or "space" for the foetus, and thus another indication of its growth and wellbeing:

²⁵ Participants seemed to resist using words invoking a sense of conflict, or of pain or discomfort caused by the foetus. This is perhaps because it does not accord with dominant understandings of good, 'sacrificial' motherhood (Baker, 2009).

Definitely in the last 6 weeks they've felt stronger like, the baby's obviously getting a bit more weight to it and a bit more muscle. Sometimes, it makes you jump, makes you kind of flinch. More so than, before they were much more gentle.

Heather, 30-34, 35 weeks pregnant

These altered sensations were largely welcomed, despite the fact that movements experienced later in the pregnancy caused discomfort for some of my participants. For example, Marisa described them as feeling like she was being “beaten up from the inside”. This was because they provided interviewees with reassurance that the foetus was not only alive, but growing as expected.

6.2.2.2 An experience that has “lost its status”?

Scholars have argued that women's knowledge of their pregnancies has become devalued as a result of the increasing medical intervention they now experience. For example, Rothman describes that where diagnosis of pregnancy was once dependent on the pregnant women herself, and the recognition of changes in her body, this is now performed by technology such as the ultrasound scan, rendering the woman invisible (Rothman, 1988: 115). Barbara Duden's (1992, 1993) historical accounts of the pregnant body make specific reference to the changing experience of foetal movements, traditionally known as ‘quickening’. Once representing the first definite sign of pregnancy, available only to women themselves, she argues that this experience has lost its status with the introduction of pregnancy tests and ultrasound technology (Duden, 1992). The experience, Duden writes, has been “eliminated by science” (1993: 80), and thus for women becomes reduced to “simply one and even a somewhat less important event along a scientifically mediated continuum” (1992: 335)²⁶.

For my participants however, once definite movements had become a regular occurrence, the reassurance derived from these seemed to be privileged over other forms of knowledge of their pregnancies. Felicity said it was the sensation of

²⁶ For discussion of the (co-)construction of medically-based knowledge as ‘authoritative’ in pregnancy see Davis-Floyd and Sargent (1997).

movements at nineteen weeks that allowed her to stop “worrying so much” about the pregnancy. Nancy explained:

When you can feel him moving you feel a lot less anxious about anything cos you think well, he’s obviously still there, and doing OK if he’s jigging about.

Nancy, 25-29, 33 weeks pregnant

In these examples the tentativeness characteristic of my participants’ (particularly early) pregnancies is described, but has begun to be addressed with foetal movements. For Gail and Ingrid, this meant that the worth of technological methods of assessing foetal wellbeing became devalued. Whereas in earlier stages of pregnancy Gail described hearing the heartbeat with the Doppler as a “good” experience, in our last interview both Gail and Ingrid presented an alternative view. Gail explained:

Before it was moving around it was like, quite amazing. And now it’s a bit like ‘yeah’ [laughs] I mean, if he’s still kicking me in the ribs then I’m quite sure his heart’s still beating.

Gail, 35-39, 35 weeks pregnant

Gail’s experience demonstrates that earlier in pregnancy, she valued Doppler technology because it demonstrated that the foetus was alive, signified by a beating heart, at a time when participants could not access such information for themselves. In early gestation, in between contact with such technologies, the pregnancy remained tentative, in large part because there was uncertainty with regards foetal wellbeing. I would argue that the value my participants placed on foetal movements, when compared with other forms of knowing the foetus, is thus attributable to the fact that this provided constant affirmation of foetal wellbeing, as opposed to the temporary reassurances provided by medical technologies (discussed in the previous chapter). Further, as observed in Chapter Five, technological means of knowing the foetus also had the potential to contribute to the ambiguity of pregnancy. For example, for some participants, viewing the scan or hearing the heartbeat were described as disembodied experiences. In addition, even the bodily experiences of pregnancy, such as sickness, were symptoms that could signal something other than a pregnancy. For instance Deborah, at eleven weeks, explained that “A lot of the time

you just feel ill”. Early changes in their body shape were also difficult to disentangle from their increased appetites. Foetal movements however, were a completely unique experience. As Heather described:

[It is] movement that, you don't, you don't get in any other way you don't get from anything else, it's just from a baby.

Heather, 30-34, 35 weeks pregnant

The notion that foetal movement has lost its status due to medical and technological intervention in pregnancy thus did not accord with the experiences of my participants. Movements represented an important means of both resolving the ambiguities of pregnancy, and reassuring women of foetal wellbeing. When asked whether they would miss being pregnant, those who answered ‘yes’ gave movements as a key aspect of this: Julia said she would miss the reassurance they provided, and Marisa described that she would miss the collusiveness of this relationship: “it’s just me and it at the moment”.

Movements also could contribute to the identification of the foetus as a *baby*, which, as discussed in Chapter Two, is a phenomenon most often associated in existing literature with technological methods of intervention.

6.2.2.3 Foetal movements and the emergence of a ‘baby’

It may be noted that throughout the quotes presented in this chapter, participants have increased their usage of the term ‘baby’ in reference to the foetus within them (as opposed to largely an imagined, future baby as seen in the two preceding chapters). Around half of my participants explained in our final interview that they had begun to think of the foetus as a baby. I do not consider this to be attributable to one moment or event. Instead, this seemed to be a gradual process, experienced differently by each of the participants who related such an experience. A minority, however, did point to specific events that they thought had contributed to this change. For Julia, this was in part related to foetal movement. Having considered the foetus to be “a baby, but a developing baby”, in our interview at nineteen weeks pregnant, during our final interview she explained that:

He is a proper baby now... mainly because he has like a rhythm, during the day, like a baby rhythm, so I expect him to kick at certain times of the day.
Julia, 25-29, 35 weeks pregnant

Nancy, Deborah, Leila, Heather and Ingrid also described that such patterns of movement had changed their conceptualisation of the foetus within them. In discussions of these sensations, Deborah reflected on how these had begun to contribute to imaginings of a personality. Here these were connected to the personality traits of her and her husband, thereby constructing kinship with the foetus:

The baby has a bit more of a schedule. And so like, yeah, after dinner from like 6 'til 10[pm] all last week it was just like 'woooo'...so, it's definitely like more of a night owl like my husband, as opposed to me. And so, you just kind of get to know its little patterns.
Deborah, 35-39, 35 weeks pregnant

She also described the baby as “cheeky”, because whenever her husband went to put his hand to feel its movements, it would stop moving (this scenario was also described by Leila, who thus declared that “it’s got a little personality”). Movements also meant that the foetus became knowable to me as an interviewer. This occurred during my final interviews with several women, including Nancy, Leila and Ingrid. Following my final interview with Deborah I wrote in my field notes that I felt as if there was already a baby present, because she would regularly articulate the foetus’ movements, often stopping mid-sentence to look down at her bump. She also demonstrated to me how she could provoke foetal movement:

Yeah, like a cup of tea, if I set it on [my bump] they're like 'ugh'. Yeah, so, you can get them to react, the baby's already moving. Yeah. Um, yeah, no it's not happy. You might even be able to see it. The feet are up here so it's pretty strong.
Deborah, 35-39, 35 weeks pregnant

Movements also provoked other forms of interaction with the foetus. For example, Gail and Leila explained that they would verbally reprimand the baby for kicking them in the ribs and causing discomfort. For Leila, this largely happened when she

was sitting down, such as whilst driving. Keira and Heather both explained that they would regularly feel the foetus' hiccups, and if this occurred they would respond, with Heather explaining that she would "rub it, and kind of try and comfort it a bit". Keira's account of this particularly suggested a sense of 'looking after' the foetus whilst in utero:

It's a shame cos sometimes you can tell it's really hating it...It'll hiccup away and then thrash around, and, it's like aw. And I don't know what to do, and you can't really do anything. So, if it's, it usually happens if I'm trying to fall asleep, so I'll kind of roll over and see if that'll help it. Poor thing.

Keira, 30-34, 35 weeks pregnant

Another important feature of movements for some interviewees, lending to the conceptualisation of the foetus as an individual, was the fact that these movements were beyond participants' control. Gail, for example, described that the foetal movements she was feeling were no longer predictable. As such, Julia said "he has his own mind that way. About whether he kicks or not". Here then, the sense of lacking control described in existing literature was perhaps more relevant to participants' experiences of the foetus, and thus interpreted in a positive light, as opposed to their changing bodies.

We see then that whilst the attribution of foetal personhood has generally been associated with the visualisation of the foetus through the use of ultrasound (Mitchell, 2001; Taylor, 2000), foetal movements could also be powerful in this regard, provoking similar narratives from women. Indeed, recent literature has also begun to demonstrate this phenomenon. One example is Roberts' (2012) discussion of 4D ultrasound imaging. She found that alongside the role played by the visual representation of the foetus in the attribution of personhood, such as its facial appearance, women also invoked their embodied experiences to interpret these images.

With the commencement of definite foetal movements however, at times came their occasional absence. This, in the context of medical advice emphasising the need for

awareness of foetal movements, could temporarily re-introduce the tentativeness expressed by participants earlier in their pregnancies.

6.2.2.4 Bodily absence and the re-appearance of tentativeness

Seven participants related that they had been concerned about foetal movement, or that this subject caused them anxiety. All were aware of medical advice regarding movement provided to them by their midwife. These official guidelines state that:

If you notice your baby is moving less than usual, or if you have noticed a change in the pattern of movements, it may be the first sign that your baby is unwell. It is therefore essential that you contact your midwife or local maternity unit (Royal College of Obstetricians and Gynaecologists, 2012).

Whilst, as we have seen, women were generally familiar with foetal movements during later pregnancy, these movements were not as clear, or as ‘patterned’ as the providers of this advice perhaps expect them to be. For example, Deborah was unclear about what counted as a movement, exclaiming that “sometimes you feel a little flutter, was that a kick?”. Leila made a trip to the hospital following a weekend where the foetus had been particularly active. She was not sure what the notion of ‘reduced movement’ was *relative* to:

On Sunday it was just, having a sleeping day or something, and it had gone completely, barely moved...they always drum in to you, if there's reduced movement make sure you get in touch with somebody...[the midwife] was a bit kind of 'are you sure it's definitely not moving?'...I'm like, well yeah I have, it's definitely reduced. Compared to those crazy few days where it was just doing everything.

Leila, 30-34, 35 weeks pregnant

There was thus confusion for women regarding the types of movement that should cause concern if they became less frequent, and with regards the assumption that patterns of movement would be consistent. Marisa was concerned that “now it's getting less space it's not gonna be able to move as much”. Though this could be interpreted as a reassurance, signalling foetal growth, Marisa saw this as having the

potential to provoke anxiety. She described the requirement for awareness of when the foetus stops moving as “something else to worry about”.

A common experience, both for those who did not articulate particular concerns about foetal movements, and for those who did, was that women were not always aware of these sensations. Keira, having just started her maternity leave when we met at thirty five weeks, explained that recently she had not been noticing movements during the day, as she had been particularly busy at work. Andrea, who had been to the hospital twice for concerns about reduced movement, was confused about how many movements she “should” be feeling, but also linked her worries about movements to her attempts to finish projects at work before her impending maternity leave:

During work, I know that sometimes it'll be variable, sometimes it'll kick and sometimes it won't, but I don't have time to focus on the times it doesn't.
Andrea, 30-34, 35 weeks pregnant

In these last examples, foetal movements seemed at times to become assimilated into women's everyday corporeal experience, with Andrea explaining that she would sometimes need to “focus” on these sensations. Foetal movements, though now recognisable as such at this stage of pregnancy, thus were at times ‘absent’ (Leder, 1990). Discourses of the foetus as an intruder (Martin, 1998), and the pregnant body as out of control (Warren and Brewis, 2004), represent the pregnant body as alien. Yet, for my participants, their pregnant bodies at times faded into the background, reminiscent of experiences of their pre-pregnant bodies. However, it was this *absence*, in contrast to pre-pregnancy and Leder's notion of the absent body, that was seen to signal potential ‘dysfunction’ and thus contributed to the tentativeness that could be experienced – women thought they ‘should’ be feeling movements, i.e. that their body (and the body of the foetus), should be *present*. When this occurred, women's attention was (re-)focused to their corporeality, re-formulating their body as an object of perception, and thus creating a distance from it (Leder, 1990: 76).

When women were unsure as to whether they had felt movements due to these instances of absence, or if they noted a lack of movement, they often sought reassurance as to foetal wellbeing. For example, they drew on methods, communicated to them by their midwives, of prompting the foetus to move. These included having a cold, sugary drink or piece of chocolate, or lying still²⁷. In addition, Felicity described:

If I'm worried that I've not felt her move for a little while I'll just like poke a certain part, and she'll just kind of wriggle a wee bit.

Felicity, 25-29, 35 weeks pregnant

These embodied methods of reassurance, when successful, negated the need to seek assistance from health professionals or medical technologies. However the majority of my participants viewed the latter as the next port of call (this shift in the authority accorded to different types of knowledge is discussed further in section 6.4, below). A minority of participants did turn to health professionals in the first instance, however. This was the case for Sinead, who telephoned a nurse after she had “not felt anything for a while”. Like Leila, this was in relation to a preceding period in the pregnancy when she had been feeling the foetus more regularly. Andrea had also been to the hospital due to concerns about reduced movement. Following her experience, Sinead described these embodied means of checking foetal movements as a “palaver”, and the next time a similar incident occurred, she used the Doppler given to her by a family member. Nancy also used her Doppler for this reason, which she had owned since her ninth week of the pregnancy. Here she draws on the ‘absence’ discussed above, describing that feeling movement may require a ‘conscious’ effort:

Sometimes if I hadn't felt him, if I hadn't like consciously acknowledged feeling him, I would still use the Doppler, like a couple of days ago, I couldn't remember if I'd felt him moving.

Nancy, 25-29, 33 weeks pregnant

²⁷ These all demonstrate the collaborative nature of foetal movement, which often necessitated the participation of women themselves.

We have seen then that though the embodied experiences of later pregnancy discussed above, of foetal growth and of foetal movement, resolved much of the tentativeness of early pregnancy, perhaps more so than the medical interventions they experienced. Despite this, uncertainty and at times anxiety remained, and in some cases was even *provoked* by embodied experience (when interpreted by others, or through its absence). However, unlike early pregnancy, embodied experiences were often also the means by which women *resolved* the anxiety they prompted.

These variations in the experience of movement, which could be absent, present or provoked, also contributed to the difficulty women had in describing their physical relationship to the foetus. This was simultaneously conceptualised as one of separateness *and* connectedness.

6.2.3 Separate or connected?

Classically, the ‘self’ has been conceptualised as a unified, whereby being is indivisible (Komesaroff, 2001: 320). With Western traditions locating personhood in the biological body, this understanding has contributed to the emergence of the foetus as already a ‘person’ (Morgan, 2011), particularly since the introduction of visualising technologies into routine antenatal care. The experiences of the foetus undergone by the fifteen women in this study were not this clear, however, as already alluded to in Chapter Five. During our final interviews, the notion of the entity within them as representing unified subject, separate from themselves, remained problematic. Indeed, even at this late stage of pregnancy, which signified the presence of a ‘baby’ for many (all but two participants, Andrea and Gail, had begun to directly refer to the foetus in this way during our last interview), participants’ descriptions of the entity within were at times uncertain.

As we have seen, the foetal entity could become assimilated into participants’ own corporeality. This was demonstrated with the periodic absence of the sensation of foetal movements, which began to (intermittently) experientially recede with their persistence over time (Leder, 1990: 72). This accords with Leder’s notion of depth disappearance, used to describe the foreignness of the inner body, generally neither

the subject nor object of direct engagement (*ibid*: 54). Indeed, Gail, one of two participants to talk this way, explicitly described the foetus in terms of a part of her inner body during our second interview. When discussing whether she does anything to interact with the entity within her, she explained:

It would be quite weird, to talk to it anyway, it would be a bit like talking to your kidney [laughs] or you know, or one of your lungs.

Gail, 35-39, 19 weeks pregnant

In her third interview, she described her response to the twenty week scan picture in a similar manner:

I guess it's like, kind of how you feel if you ever get X-Rays of yourself, you're like 'wow that's my bones and that's my, kind of, vein' or whatever, it's like, it was just more kind of amazing that you could see inside and see what was happening.

Gail, 35-39, 35 weeks pregnant

This awareness of the situated-ness of the foetus within their bodies was commonly articulated in relation to ultrasound scans. Here Felicity described the foetus at the twelve week scan as “bouncing from one end of the uterus, up to the other”. In later pregnancy, and in the absence (for the majority) of visual information, awareness of the foetus’ situation within their bodies was most often discussed in relation to what my participants ate or drank, and in terms of foetal movement. Ingrid connected foetal movements, or their absence, to what was happening within her body during our third interview. She said that she thought the baby was quiet that morning, due to the fact that she had had a flu jab the day before. During our third interview, prior to articulating the foetus’ excited reactions to the cake and hot chocolate she had consumed, Deborah described:

I think the connection is like, I eat and then like, and hour later the baby's like 'wooo'.

Deborah, 35-39, 35 weeks pregnant

Beth demonstrated the intertwining of the technological and the embodied in providing knowledge of the foetus. Having been to her twelve week scan, during

which she was informed that the foetus was measuring small for her gestational stage, she underwent a second scan a week later. This was provided due to the initial difficulty the sonographer had in measuring the nuchal fold. Here, she was told that the “baby had caught up”. Beth explained:

I'd been absolutely starving that week...and I was going 'I think there's a growth spurt going on', and I'd have my bowl of porridge, and my banana and everything when I get into work, and then I had my elevenses...I was so hungry. And erm, she says 'oh yeah, he's definitely got a bit bigger'. I was like 'tell me about it, I've been eating like a horse all week'.

Beth, 35-39, 19 weeks pregnant

Participants thus often articulated a sense of the foetus as an element of their inner bodies; provoking, but also responding to, their own behaviours and consumption. Participants' conceptualisations of the foetus were therefore not in terms of a distinct and bounded being, separate from a similarly bounded self, but instead emphasised their interconnectedness with the foetus, which mutually shaped and was shaped by their bodies and behaviours. Lupton (2013a) also discusses the inseparability described by my participants. She describes this intertwining of bodies experienced during pregnancy as an example of ‘interembodiment’, or ‘intercorporeality’, terms used to describe the experience of one’s embodiment as continually mediated by our interactions with other (including non-human) bodies (Weiss, 1999).

As discussed in Chapter Two, scholarship largely in the field of feminist philosophy has thus reflected on the uniqueness of the experience of pregnancy, and demonstrated that it calls the presumed unity of the subject into question (Young, 1984; Tyler, 2000)²⁸. In scientific discourses, this unique relationship between woman and foetus is often depicted as antagonistic. This has been attributed to conceptualisations taken from immunology, which see the body as designed to attack entities that do not form part of the ‘self’ (Fannin, 2014: 299), and draw on metaphors of invasion or intrusion (Martin, 1998). However, recent work in this field has contributed to a call for the reconceptualisation of maternal and foetal

²⁸ Though as Lundquist (2008) demonstrates, this is most often discussed in the context of wanted pregnancies.

bodies. Advances in the understanding of ‘microchimerism’, the bi-directional transfer of cells between a woman and the foetus during pregnancy (Martin, 2010: 24), may signal a shift in understandings of pregnancy as a process of individuation, to one incorporating permeable and interdependent bodies (Kelly, 2012: 252). This concept depicts the maternal-foetal relationship as relational, pointing the inability to consider the foetus as separate from the woman who carries it. Similar sentiments have also been voiced in work on the placenta. Developed between a woman and the foetus for the duration of the pregnancy, attention to the placenta challenges the portrayal of a ‘free floating’ and independent foetus (Maher, 2002). The placenta encapsulates the intertwining and embodied nature of the connection between these two bodies, and has been said to represent their relationship as one of ‘gifting’ and ‘generosity’, as opposed to conflict (Hird, 2007). These accounts better accord with the experiences of my participants, who as we have seen, at times discussed the mutual shaping of their bodies and actions, and those of the foetus.

However, as intimated above, interviewees’ descriptions of the foetus and their connection to the foetal entity were not fixed. At times they also described the foetus in terms of a separate and bounded being. This was most evident in discussions of ‘viability’, a concept to which we now turn.

6.3 Viability

It has been noted that during the final trimester of pregnancy, women’s embodied experiences provided some resolution of the tentativeness they had earlier experienced. However, medical discourses also contributed to this, most notably those surrounding the concept of viability. According to obstetric definitions, the threshold of viability refers to the “lower limit of foetal maturation compatible with extrauterine survival” (Cunningham et al., 2009: 807). The concept is perhaps most associated with bioethics, neonatal care and the law, and is mobilised in debates with regards abortion (Cohen, 2011), but also surrounding premature birth (Pignotti and Donzelli, 2008). Nevertheless, it is a concept with which the majority of my participants were familiar. Indeed, ten of them referred to the term, or drew on the notion without naming it explicitly.

I suggest that their appropriation of this concept to denote a *stage of pregnancy*, as opposed to the gestational age of the foetus, is connected to my participants' attempts to manage tentativeness, most keenly felt earlier in the pregnancy. As a result of the new meaning they gave to this concept, and in combination with the ability to self-monitor the pregnancy thanks to their embodied experience, by the time we met at around thirty five weeks participants were much more relaxed with regards the safety of the pregnancy, but also wellbeing of the foetus.

6.3.1 Unstable definitions

The point at which a foetus becomes 'viable', or able to survive independently of the woman carrying it (though nevertheless often requiring extensive medical assistance prior to 26 weeks (Seaton et al., 2013)), is not clearly defined. As alluded to above, this may be due to disparate disciplinary engagement with the concept. A well renowned obstetric textbook defines the period from twenty two to twenty five weeks as the "threshold of viability" (Cunningham et al., 2009: 806). However, according to the Nuffield Council on Bioethics, which commissioned a report on *Critical Care Decisions in Fetal and Neonatal Medicine*, a live birth at the 'borderline of viability' takes place up to and including twenty five weeks and six days of gestation (Nuffield Council on Bioethics, 2006: 33). The Nuffield Council's report, which informs research and medical practice, recommends that:

Between 24 weeks, 0 days and 24 weeks, six days of gestation, normal practice should be that a baby will be offered full invasive intensive care and support from birth and admitted to a neonatal intensive care unit (*ibid*: 33)²⁹.

Echoing the inconsistency demonstrated in existing literature with regards the definition of viability, my participants also held different interpretations of the point at which the foetus they carried became viable, and what they understood viability to

²⁹ This resonates with abortion law in England, Scotland and Wales, whereby abortions carried out after twenty four weeks gestation are subject to greater restrictions, being only permitted in cases with a substantial risk of serious abnormality, or in the case of a risk to the woman's life (Statham et al., 2006)

represent. Deborah and Eve for example, described that at twenty eight weeks the foetus would be able to “live”, or “survive”, “on its own”. Sinead and Julia described that the point was at twenty four weeks, with Julia explaining:

If you deliver after twenty four weeks, [medical professionals] 'll do something about it so, yeah [I've been] a bit more relaxed since then.
Julia, 25-29, 35 weeks pregnant

Keira defined viability as occurring at twenty five weeks, whereby the baby would have a “good chance” of surviving. Viability was thus a revered time point in the pregnancy for the majority of my participants, firstly because it signalled the possibility of the foetus surviving independently. Secondly, it prompted participants to consider the foetus in terms of a separate (potential) ‘individual’. We shall consider these in turn.

6.3.2 Viability and shifting perceptions of risk

Despite the uncertainty surrounding the concept, the notion of foetal viability proved to be important to many participants’ ability to ‘relax’ about the pregnancy. As demonstrated in previous chapters, early pregnancy, prior to twelve weeks, was marked by uncertainty and the threat of pregnancy loss. Following this, the period up until twenty weeks represented a series of technological interventions to overcome, which as well as offering the potential to confirm the progression of the pregnancy, were simultaneously seen by some to signal the possibility of an upsetting outcome with regards foetal health (Rothman, 1988).

In contrast, the next medically constructed milestone articulated by participants, ‘viability’, seemed to unreservedly signal a point of safety. *Ready Steady Baby!*, the resource provided to women by the NHS, contributes to this view, explaining that at twenty four to twenty five weeks:

Your baby is viable – that is, some babies born at this stage have gone on to survive (NHS Health Scotland, 2012: 59).

Participants also obtained information regarding viability from various websites and online message boards. Julia said that on one Internet message board, this point was celebrated by other members of the forum as “V-day”, and as we have seen, she therefore described that she felt more ‘relaxed’ following this point. Unfortunately, the importance of this milestone only emerged as the interviews progressed, and as such I did not interview women at this particular point in time. When we met several weeks later however, at around thirty five weeks, women reflected on the fact that they had passed the point of viability, and that as such they felt less anxious. For example, in line with the notion of foetal viability, two participants explained:

Now he could definitely survive outside...they could just do a C[aesarean]-section and put him in the incubator and he'd probably, statistically, be OK.
Gail, 35-39, 35 weeks pregnant

From a couple of weeks ago I remember they said if your baby's born now, you have like a really small chance of things going wrong, including like needing any help after they're born.
Nancy, 25-29, 33 weeks pregnant

Heather said that she had felt more positive about the pregnancy since passing the threshold of viability, and when meeting at thirty five weeks reflected “if I did go into labour, today, then, you know, it would be OK”. Of course, medical discourses of the concept alone did not account for women’s interpretations that the foetus was now viable, hence leading them to engage with the pregnancy less tentatively. We must also attend to the fact that these discourses resonated with participants’ experiential embodied knowledge. Several participants understood that the foetus was ‘viable’ because the major aspects of development had been completed (Nancy and Julia, highlighted an organ they saw as particularly important to the foetus’ survival; the lungs). By the time we met for our third interview, many participants thus inferred that until the end of the pregnancy, the foetus would mostly be gaining weight. For example:

I feel the baby's like pretty much there, all it's doing is putting on fat, so it's kind of like the finished article.
Marisa, 35-39, 35 weeks pregnant

The baby has reached a lot of its, um, milestones, so now it's like, your baby's putting on fat...it definitely seems like the, all those big developmental things are passed.

Deborah, 35-39, 35 weeks pregnant

This, as discussed above, accorded with and was thus substantiated by their experience of foetal growth. Participants ascertained this visually, through the need to purchase maternity clothes during the later stages of pregnancy, but also through the change in foetal movements over time.

We have seen that the point of viability was viewed by those who discussed the concept as a stage of pregnancy, transposed from the contexts in which it usually operates (neonatal care and abortion law). Following this point (described to me as occurring at different gestational times), participants became more confident in the health of the foetus, and the likelihood of a successful pregnancy. They understood that even if the pregnancy were to end prematurely, it would nevertheless result in a baby. The weight given by women to the concept of viability, in a context where their pregnancy had been constructed as tentative due to medical discourses of pregnancy loss (and substantiated by experiential knowledge), again demonstrates the shaping of women's experiences through biomedical discourses. Here, against the 'tentative' experience of contemporary pregnancy, participants positioned medicine as a source of certainty and security, able to rescue their babies in the event of a very premature birth. This is despite the fact that at this stage survival cannot be guaranteed. A recent study in England found that the percentage of babies surviving to discharge (between the years 2006-2010) for those born at twenty four weeks and twenty five weeks was 44% and 67% respectively (Seaton et al., 2013). Participants, however, did not make reference to these statistics. The positioning of medicine as uniquely able to safeguard their baby, in the event of a premature birth, may be said to further contribute to the continued dominance of the medical management of pregnancy in the contemporary UK (also discussed in Chapter Two, Section 2.2.2.2).

Nevertheless, the concept contributed to the majority of my participants feeling able to increasingly conceptualise the foetus as a person as time went on, and begin to feel

more comfortable buying baby clothes and other items, including these needed for the birth. Viability contributed to a less stringent engagement with practices of emotion work including distancing and repressing excitement, outlined in Chapter Four. Sinead expressed this well when she said:

As the risks diminish, and the, and the potential heartache of losing something reduces, it becomes more of a baby, I guess.

Sinead, 25-29, 33 weeks pregnant

An important exception to these experiences however was Andrea. Unlike others, in our last interview she described that she was still trying to avoid conceptualising the foetus as a baby, for example describing that “I’m talking like it’s body parts, but I’m not thinking that way. Like a head, it’s like head in a kind of, like it as an object, as opposed to a head that has a brain inside it and a personality”. She described how her experience was different from other pregnant women’s:

I just can’t imagine thinking about it as a baby. I dunno it just doesn’t, I haven’t really connected to it at all. I heard some people turn ‘round and say, yeah that they can imagine it as a little person all the time, but I just don’t...I think it’s a self-preservation thing. I think. Even, and even though I have had a bad experience, um, and I’ve known so many people who have, and I don’t, I don’t think it makes life any easier, I don’t think that by disconnecting yourself it would make it any easier if it all went wrong.

Andrea, 30-34, 35 weeks pregnant

Here, in contrast to Sinead, Andrea articulates continuing her attempts to ‘self-preserve’ and ‘disconnect’ from the pregnancy, echoing Rothman’s (1988) concept. She also questions the efficacy of this. For the majority of participants however, their perception of diminishing risks, and thus reduced tentativeness, contributed to their conceptualisation of the foetus as a (future) baby. Another important factor was their understandings of its ability to survive independently of their bodies.

6.3.3 Viability and the foetus as ‘individual’

In a departure from existing literature, for many of my participants it was only once they had reached this later stage of pregnancy, having passed the point of foetal viability, that they began to consider the foetus as a (for some, potential) *individual*

separate from themselves (though as observed in Section 6.2.3, this was also interspersed with feelings of connectedness and *inseparability*).

Participants who conceptualised the personhood of the foetus in this way did so by emphasising the foetus' biological body. For most it was its capacity to survive independently that allowed them to consider it as an individual:

[Earlier in the pregnancy] I was still thinking that it was kind of a part of me, rather than as a, a person in its own right. And there was a date, it must have been, sort of like twenty five weeks or something...[a foetal development update] said like 'your baby can now have a good chance of surviving if it was born' like it would obviously be quite poorly and would have been really early, but I remember thinking, 'oh my goodness, it's a proper person'...that made me think, wow. And started to think about it as a, yeah like a separate being rather than just something that was happening in me.

Keira, 30-34, 35 weeks pregnant

Viability thus marked a specific point at which Keira saw the foetus as a being separate from herself. This is despite the fact that it would not necessarily survive without her at this stage. For Keira, it was the potential for it to survive without her that made her able to conceptualise it as something other than a part of her body. The ability to survive on its own was also a prompt for Nancy, Eve and Heather to view the foetus as something separate from themselves. Sinead also began to reflect on the foetus' status as individual with the concept of viability, however a little later she also pointed to a specific aspect of the body which signified the foetus' status as separate to her:

The survival rate increases, every week after [twenty four weeks], it becomes more, I dunno, less reliant on me, to sort of keep him alive I suppose, and have my body working in the correct way, and all that sort of stuff, it becomes more of an individual...he's not a part of you, he's got this placenta which has, well, this cord...so, that's his blood, you know, that's different to mine...not even the cord is mine, that's his.

Sinead, 25-29, 33 weeks pregnant

We see then that along with their bodily experience of movements, which provided them with knowledge about the foetus' 'personality', women's understandings of the foetus as possessing a 'body', distinct from their own, played an important part in

interviewees' attribution of foetal personhood. This accords with an individualistic notion of the person, which has been contrasted with the relational conception of personhood (acquired through social interaction), characteristic of many non-Western cultures (Conklin and Morgan, 1996). Historically, feminist authors have called for a move towards the conception of personhood as relational. Such an approach would deny foetal personhood due to its inability to form relationships, and thus re-position women as the subjects of their pregnancies. However, Morgan (1996) argues that this position fails to encompass the experiences of women themselves, for whom the distinction between 'social' and 'biological' birth is becoming increasingly blurred. My participants' experiences have resonated with both of these positions. Interviewees demonstrated their understandings of foetal personhood to be ambiguous, temporary, and influenced by their stage of pregnancy, as well as perceived levels of risk. They also saw personhood as rooted in their embodied experiences of the foetus' size and inferred 'personality', but simultaneously in the medical definitions of development and viability.

Indeed, for many participants, discussion in our last interview often focused on the notion of person or baby, but an 'unfinished' one. For example, though Nancy maintained that she was carrying a baby, she also described that "in a fortnight's time, [the] baby is fully cooked". Heather retained confusion about the entity she carried. After I questioned her about her use of the phrase "When it's a baby" she explained:

I know it's a baby now, it's just it's not [laughs], it's not quite a baby. I don't know what it is.

Heather, 30-34, 35 weeks pregnant

Though women's conceptions of the foetus were less ambiguous than in earlier stages of pregnancy, due to regularly occurring embodied knowledge of the foetus and decreased levels of risk, they nevertheless maintained an element of uncertainty with regards this entity. Discussions of the foetus in terms of either a 'person' or 'non-person' thus do not account for the complexity of my interviewees' experiences, even in later pregnancy (see also Lupton, 2013b: 118).

Viability, however, did play an important role in allowing women to conceptualise that they were carrying a separate being from themselves. This seemed due to their recognition of a body that was independent from their own, but was perhaps also due to the reduction in risk this signalled. This prompted some of my participants to 'relax' about the pregnancy, and thus allow themselves to accept the presence of a baby, earlier prevented, in part, by their stringent emotion work in this regard. Like in early pregnancy, we have thus seen how medical discourses have constructed their objects: in early pregnancy a 'risky' and 'vulnerable' foetus, before presenting women with a 'viable' foetus at (approximately) twenty four weeks. These discourses not only shaped women's experiences of pregnancy, but also their emotion work with regards these experiences. However, as highlighted by a recent anthropological study of viability in a maternity unit, the concept, which for most of my participants represented an important milestone, is a product of social, medical and legal practices, predicated on medical time, but with decisions regarding the care of very premature babies at times being passed to parents (Christoffersen-Deb, 2012). The 'point of viability' is thus contested, dependent upon judgements of clinicians but also families. As we have seen, my interviewees similarly held different understandings of the point at which viability occurred, and what was signified by the term.

Nevertheless, for the majority of participants, once this point in the pregnancy had passed, and in conjunction with their embodied knowledge, they described becoming more relaxed about the pregnancy. As we shall see, this had consequences for women's interactions with health-related advice and midwives.

6.4 Reduced risks and increased confidence – shifting engagement with sources of knowledge

As observed in Chapter Four, during the first twelve weeks of pregnancy, women particularly welcomed contact with health professionals. Feeling anxious with regards the safety of the pregnancy, or as to whether they were actually pregnant, the booking appointment at around eight weeks (temporarily) alleviated some of the

uncertainty they had been experiencing. They largely felt pleased to be part of a system of care, which additionally helped to make the pregnancy more real. Some women were even surprised when they were not subject to more checks, including a pregnancy test, expecting more intervention than they were offered.

The nature of these interactions changed, however, as the pregnancy progressed. This was particularly marked towards the end of pregnancy, when some participants openly questioned the information or advice received from health professionals or resources. I interpret that this was in part due to the resolution of the earlier tentativeness women had experienced, resulting from their changed bodily experience of pregnancy, and linked to this, perceptions of reduced risks.

6.4.1 Embodied knowledge and resolving uncertainty: the “steady curve”

In contrast to the uncertainty characteristic of early, and to a lesser extent mid-pregnancy, we have seen that the bodily experiences of later pregnancy provided women with knowledge of foetal growth, but also wellbeing (perceived through foetal movements). Another important aspect of later pregnancy was that the changes experienced by women had slowed down, having become expected and even predictable.

This seemed to give women confidence in their bodies and the sensations they were experiencing. Women described feeling “good” and “well”, and also more “relaxed” – in contrast to the first trimester of pregnancy, which was for many characterised by at times unpleasant and unfamiliar bodily experiences, including nausea, and also uncertainty. As discussed, by later pregnancy, their pregnant bodies could at times become ‘absent’. Some described the assimilation of foetal movements into their corporeal experience. Several participants described this contrast:

I mean, a, a lot of, especially at the beginning where you're just so freaked out about it, now I feel like the body changes are a little bit different. You know so it'll be like, just your standard ones where you think, back ache, pelvic pressure, pee all the time, you know heartburn. It's not the same things

where you're like 'why am I getting a bloody nose?' ...it definitely seems like the, all those big developmental things are passed, and the symptoms are just the expected ones.

Deborah, 35-39, 35 weeks pregnant

It is also of note that, as discussed above, Deborah perceives that the developmental changes in the foetus are related to her experience of pregnancy symptoms, emphasising the sense of 'connectedness' she articulated above. Andrea also seemed (a little) more relaxed in our final interview:

I'm kind of, I know, especially the last couple of weeks that I know what um, cos you change, it keeps changing, but you know what to expect because it's, it's a gradual increase of what you were having, a week ago. Whereas when you're, when you're twelve weeks, up until then, you kind of, get your symptoms which come and go, and then they disappear, and then it all kind of changes to different feelings and, whereas now it's much more of a steady curve, of the same feelings over and over.

Andrea, 30-34, 35 weeks pregnant

Here then, Deborah and Andrea emanate a sense of calm and certainty, with little talk of anxiety with regards the safety of the pregnancy (though this did emerge at other times in Andrea's final interview). This was also demonstrated in women's decreased engagement with the weekly updates they had been receiving. My participants thus seemed more comfortable and confident in their pregnant bodies on meeting for the final time; many of the embodied uncertainties of early pregnancy having been resolved. We have seen, then, that experiential knowledge could now provide certainty and information about the wellbeing of the foetus, but also about its size and position. I argue that this simultaneously led to a shift in the value women perceived of other forms of knowledge, including that offered by health professionals.

6.4.2 Changed interactions with health professionals and prenatal advice

By the time we met for our final interview, participants were meeting with a midwife (or GP where surgeries 'shared care') approximately every three weeks (this would soon change to weekly once they had reached thirty seven weeks – see Appendix I).

Participants discussed their midwife appointments with a degree of indifference in our last meetings, contrasting with the sense of ‘reality’ brought by their booking appointment at eight weeks, and the emotions of first hearing the heartbeat at their sixteen week meeting with the midwife. By our last interview, Beth described that “you’re just in and out”, and Gail explained that “there’s nothing to do really apart from go ‘are you still fine?’ ‘yes I’m still fine’”. Keira and Andrea felt that though these appointments were relatively infrequent, and did not involve a great deal of intervention, this was a positive sign:

[Midwife appointments are] not that often actually...it kind of normalises it to be honest, it makes me think like, they don’t need to see me that much because if everything’s going to plan, what else is there to say?

Keira, 30-34, 35 weeks pregnant

Nevertheless, women still very much welcomed these appointments, appreciating both the verbal reassurance from the midwife (discussed in existing literature as an important function of midwives’ interactions with women (Bredmar and Linell, 1999)), and that provided by the heartbeat monitor. Though, as we saw, this was not *as* valued by women once they had begun to start feeling definite movements. They also all appreciated the blood tests they were given at a select few appointments. Their gratitude for these reflected the degree of tentativeness that still remained for some participants during the later stages of pregnancy. Felicity reflected the views of all of my participants when she explained: “I would rather them check things to be on the safe side”. There was thus a degree of awareness amongst participants that a successful pregnancy was not guaranteed. As Heather explained, she still has “very mild” thoughts with regards this issue, due to the fact that “they can’t test for everything”.

Due to the information provided by their embodied knowledge, combined with notions of viability, women were generally more confident in their pregnant bodies. I interpret that this also seemed to give some the confidence to question forms of knowledge typically regarded as authoritative (Browner and Press, 1997). For example, as time progressed, a minority of participants expressed that they had become more relaxed vis-à-vis their engagement with advice concerning food and

alcohol consumption. Though these shifts were not dramatic, they are indicative of some women's changed perceptions of risk to the foetus over the course of the pregnancy. For example, Beth explained:

I was, laying off coffee, in the very early stages, erm, and tea, sort of caffeinated stuff, caffeine but, erm, I haven't really gone back. I've gone off coffee a wee bit...so I'm more on to the tea, and I'm just like well, there's caffeine in tea and things, but I think because it's not the early stages anymore I'm kind of like, well, it's fine.

Beth, 35-39, 34 weeks pregnant

She explained that she was more "fraught" in the early stages, because she was "nervous in the first few months, that everything would be OK". Had she had a glass of wine and then miscarried, Beth said that she would never have forgiven herself. Now, Beth gave the impression that a pregnancy loss did not pose as great a threat. This highlights not only Beth's changed views with regards the safety of the pregnancy, but also the fact that her initial refusal to drink alcohol was not only to protect the foetus, but also herself and her emotions. Marisa held similar understandings with regards the safety of the foetus:

I think, I'm not as careful about what I eat, as I was in the first trimester. Um, like the odd kind of like soft boiled egg...I feel the baby's kind of like pretty much there, all it's doing is putting on fat er, so, it's kind of like the finished article so I don't want, I mean, I'm not deliberately trying to kind of poison it or anything like that, but, um, if there's, if I have a little bit of something that maybe I shouldn't do, I don't, I don't particularly worry about it too much. You know. Um, yeah I'll maybe have, at the weekends I might have like two glasses of wine. Woo hoo! And I don't feel guilty about it at all.

Marisa, 35-39, 35 weeks pregnant

Marisa and Beth both interpreted that the foetus had largely surpassed all of its developmental milestones when we met at thirty five weeks, and was thus not as vulnerable to harm as in the early stages of pregnancy. This interpretation was not only allowed for by medical discourses of foetal development and viability, but also through their embodied experiences of noticeable foetal growth.

Eve's reasons for altering her approach to exercise and drinking coffee in later pregnancy were in part due to her understanding that the foetus was no longer fully

reliant upon her. She explained “at this stage if everything goes normally, there’s some sort of reassurance in knowing that, if things kick off then that’s fine and that, well, it should be fine”. She also reflected upon the unrealistic expectations inscribed in much of the prenatal advice she received:

I feel like at the start, I was aware of a lot of the same information as I am now, as far as like the advice they give you about exercise and diet and things...I was excited so I was happy to do that, in a way. But then after a couple of months you’re like, hmmm, I’ve got, I’m not even halfway there yet, and then if you breastfeed thinking about, you know, you’ll have the same issues as far as like diet and, so you’re like oh, come on now, let’s get, let’s get real about this.

Eve, 25-29, 35 weeks pregnant

In addition to the new found confidence with regards the safety of the pregnancy, demonstrated by Beth and Marisa, Eve explained that in reality, prenatal advice was difficult to reconcile with her lived experience. As she explained “I’m only human and you can’t be going around like, living this perfect life”. In the above quote she also makes reference to the ‘absence’ of pregnancy following the more tentative stages, discussed earlier in this chapter. Where she was “excited” about the pregnancy at first, she implies that this has waned, with her pregnancy perhaps fading into the background. For Eve, and others, as highlighted by Lock and Kaufert (1998a), reproduction thus does not consume, but is just one aspect of, women’s multi-faceted lives.

Heather demonstrated the most outright questioning of the advice provided by health professionals, in this case by her midwife. After having been told that her body mass index (BMI) was slightly low at her booking appointment, Heather’s midwife later suggested she undergo two additional growth scans, at twenty eight and thirty two weeks.

I went for the twenty eight week scan and felt completely fine about everything, so I cancelled the thirty two week, and I just said, you know, I don’t think it’s necessary, I’m not worried...there was nothing to say that there’s a problem...And because I was, 0.5 below my BMI in February, that’s the only reason why they’re kind of being cautious about it. And to me that’s

such a tiny, thing, that then creates the potential for low growth, but not actual low growth.

Heather, 30-34, 35 weeks pregnant

Here, Heather seems to be resisting biomedical knowledge and intervention. She described that she felt confident about her pregnancy, explaining “I feel like [the foetus is] healthy because I feel healthy”, implying a privileging of her embodied knowledge of the pregnancy. However, the narratives of my participants did not reflect such a simple juxtaposition of ‘biomedical’ with ‘experiential’ knowledge. As also demonstrated by participants in a recent study by Markens et al (2010), women draw on a variety of knowledge sources in decisions regarding prenatal advice and diagnostic technologies. For example, explaining her decision to decline a second scan, Heather drew on the measurement of her BMI and information from her maternity notes (exclaiming “look at the graph, it’s fine”), as well as her embodied experience (see also Markens et al., 1999). In turn, midwives request information about women’s embodied experiences when assessing prenatal health, as well as invoking medically defined thresholds such as fundal height³⁰. It is therefore misleading to consider that two sets of knowledge, that of medical professionals and that of women, exist in opposition (Abel and Browner, 1998; Shaw, 2002; Markens et al., 2010).

I therefore do not interpret Heather’s decision to decline her second scan, or Marisa’s decision to have a small amount of wine despite guidelines advising to avoid it, in terms of a rejection, or a distrust (Markens et al., 2010) of these forms of knowledge. I instead see these as based on the perceived *value* of various knowledge sources. Those most valued shifted throughout pregnancy. For example, many of my participants seemed to be bound to medically-based descriptions of pregnancy during the first trimester. These included foetal developmental updates, and statistics regarding miscarriage, as seen in Chapter Four. Though, this is not to say that it went unquestioned; for example Andrea challenged the estimation given for her due date, and Gail had various objections to advice regarding foods to avoid. I suggest that this is because, in the absence of discussion with friends who had experienced pregnancy,

³⁰ The distance from the pubic bone to the top of the uterus, used to estimate foetal growth.

and in view of their uncertain embodied experiences, this was one of the few forms of knowledge they were able to access. As they reached the final weeks, I noted that during interviews, participants more often questioned medically-derived measurements and thresholds. This was true of the measurement of fundal height, which for all women is expected to correspond to their gestation in weeks (for example at thirty three weeks women were expected to measure thirty three centimetres). Four of my participants exclaimed that this was ‘crazy’ or ‘bizarre’, due to its arbitrariness, and two described it as ‘archaic’ or ‘low tech’. Though many explained that they found the measurement reassuring, I suggest that such knowledge was no longer as valuable to them, as they could now discern the foetus’ size and growth from their embodied experience, and draw on the indirect experiential knowledge of friends and family. For example, though others had pointed out that Gail’s bump was small, she explained:

[My friend] was pretty worried, actually when she got sent for [a growth scan]. But, [her] baby was totally normal sized inside. Which has maybe made me a bit more like, I’m sure he’s like, normal inside. Cos I know how, petite she is in general, and to have a normal size baby fitting inside her, I can see that, it could easily be hidden inside me [laughs].

Gail, 35-39, 35 weeks pregnant

Whilst the measurements and classifications mobilised by midwives were welcomed by women, in many ways these were not as valuable as their bodily experiences, which provided regular, as opposed to intermittent, knowledge about the pregnancy, and also knowledge that was specific to *their* pregnancy, in contrast to the universalising guidelines used by midwives. Participants however, did recognise the expertise of midwives, though this was often located in experience. For example, two of my interviewees, including Nancy, commented on the fact that their midwives were young, and speculated that this may have contributed to why they were unhappy with their care (see also Markens et al., 2010: 42 for discussion of experience and trust in prenatal diagnosis). Gail, in contrast, had an older midwife. Though her midwife did not follow standard procedure when assessing Gail’s growth, instead using only a visual judgement, Gail commented that:

She could have decades of experience, and if she prods and says it's the right sort of size then, whatever.

Gail, 35-39, 35 weeks pregnant

Participants also judged expertise on the personality of their midwife, with two indicating that they did not trust their midwife's judgement due to the fact that she was "ditsy" (Heather) or "away with the fairies" (Felicity). We see then that expertise was not necessarily located by participants in professional training, but also could be discerned from an individual's age or demeanour. Many women also often asked for the advice of family and friends, merely due to their having experienced a pregnancy – for example Leila would often text her sister to ask questions, as opposed asking her midwife during appointments. In accordance with Collins and Evans (2002), participants thus recognised multiple forms of expertise, seen to be of changing value throughout the pregnancy. At times this was located within women themselves. For example, several criticised the antenatal classes given by midwives, with Nancy (having expertise in delivering presentations) asserting that she could have delivered "a better antenatal class, just from things that I've read".

6.5 Conclusion

This chapter has contrasted the different experiences undergone by women within a single pregnancy. Early pregnancy was marked by new and uncertain bodily experiences. These, along with medical discourses of risk, contributed to a heightened sense of tentativeness. This contrasted starkly with later pregnancy, which was characterised by anticipated bodily changes, and discourses of foetal viability. We observed that for many participants, the resolution of a large amount of this earlier tentativeness was due to their embodied experiences, which provided reassurance of both foetal growth, and foetal wellbeing (though these were interconnected). For many, this was valued over the reassurance that could be provided by technological interventions. The experiences of my participants thus challenged two sets of existing literature: those arguing that women's experiences have become devalued in the face of technological intervention, but also those describing women's experiences of their pregnant bodies as 'out of control'. Indeed, women welcomed the growth of their bump and regular foetal movements, and as

these were anticipated features of pregnancy thanks to their common sense knowledge, felt that their bodies were changing as they should, rather than seeing these changes as unruly or unpredictable.

Also of note is the fact that participants' embodied experiences of these changes and of the foetus at times became assimilated into their corporeality, becoming absent in accordance with Leder's (1990) description. This was perhaps indicative of the fact that for the majority of participants, this period of pregnancy was no longer characterised by anxiety (in contrast with Nancy's early experience, where she described checking for blood when using the toilet). I argue that these changes led to a feeling of 'embodied certainty' for participants. The changes they were experiencing became more gradual and predictable, thus indicating that pregnancy was progressing as it 'should' (though for Nancy, the body remained very much present in her experience of later pregnancy, due to the discomfort she was experiencing). As we have seen these feelings of certainty and familiarity with their changed bodies, and anticipation of future changes, contributed to the reduced tentativeness experienced by women in late pregnancy. Yet, this certainty was not stable. The tentativeness of early pregnancy could at times re-emerge, stemming from the comments of others, or from medical discourses regarding foetal movement. These discourses did not account for the unpredictability or occasional 'absence' of these movements.

A significant milestone for the majority of my participants, additionally contributing to a reduction in tentativeness, was that by the time we met at thirty five weeks they had passed the point of foetal viability. As we have observed, this is a contested concept when used in medical and legal discourse, but also as described by my participants. My interviewees discerned that if born at the point of viability, there was a chance the baby could survive. However, none provided information with regards the likelihood of this happening. Indeed, though readily available with regards the risk of miscarriage in the first trimester, statistics regarding a baby's survival if born around the point of viability are more difficult to access. The information regarding viability provided in the NHS resource *Ready Steady Baby!* is

brief. Nevertheless, this seemed to be a concept well known amongst many of my participants, who as we have seen, throughout the course of the pregnancy conceptualised time in terms of ‘milestones’ to surpass.

By the time we met at thirty five weeks, many participants talked in terms of a good chance of the baby’s survival if born at this stage, and that by this time there were no more developmental milestones to pass. The discourses of risk so pertinent to women during the first trimester, were less often articulated (Andrea was the only one to discuss the possibility of stillbirth, giving me a statistic of one in two hundred, during our final interview). As such, in combination with the increased comfort with their now gradual bodily changes, women less often described engaging in the emotion work so characteristic of their first trimester. This also led to shifts in their interactions with medical advice and health professionals. Women experienced their midwife appointments as routine and predictable, and some also began to become more relaxed with regards health advice that they had followed more strictly during early pregnancy.

The fluidity of experiences undergone by women within a single pregnancy was observable through significant shifts in emotion work, the shifting valuation of various forms of knowledge, and changed interactions with health advice and professionals. The implications of my participants’ experiences for the conceptualisation of pregnancy in sociological literature, and for future research, will be discussed in the following chapters.

Chapter Seven

Discussion: the tentative pregnancy re-visited

7.1 Introduction

This section of my thesis reflects on the preceding data chapters in the context of existing literature. I pay particular attention to Rothman's (1988) concept of the tentative pregnancy, and its relation to my fifteen interviewees' experiences over the course of gestation. I argue that my participants' articulations of tentativeness, which varied over the nine months of gestation, arose from their shifting experiences of pregnancy as at risk, and related to this, as uncertain. This marks a departure from existing literature, which often attends to the concept of risk in pregnancy, but neglects or decouples this from uncertainty. Further, I also see women's accounts of tentativeness as connected to the ambiguous position they occupied at times, due to their occasionally unclear embodied experiences, and the elusiveness of the foetal entity. I explore how these experiences all shifted over time, influenced by medically situated discourses of risk, medical technologies, and embodied experiences. The last section of this chapter focuses on the consequences of shifting experiences of tentativeness, in terms of participants' engagement with various forms of knowledge over the course of gestation. In the final part of this chapter, I re-visit Rothman's concept, describing its value to understanding experiences of a first time pregnancy in a contemporary UK context.

7.2 The tentative pregnancy

This thesis has drawn on Rothman's concept of the tentative pregnancy, originally developed in the 1980s to describe the experiences of women undergoing amniocentesis. The women experiencing amniocentesis in Rothman's work had been designated as 'at risk' of carrying a foetus with a developmental condition, in most cases due to their age. The procedure, taking place during the second trimester of

pregnancy, was offered as a means of diagnosing any such condition (Rothman, 1988). As a result of their encounters with amniocentesis, Rothman describes that these women experienced their pregnancies as tentative. She explains that the decision to undergo this test, and period of waiting for results following the procedure, leaves women experiencing months of waiting ‘in limbo’, “unsure whether they are mothers, or carriers of a defective foetus” (Rothman, 1988: 7). According to Rothman, the experience of pregnancy as tentative shapes women’s engagement with their pregnancy. This includes the flow of gestational time, their experiences of foetal movement, and their ability to feel that they are pregnant (see also Tymstra, 1991). Rothman argues that this changed experience of pregnancy ultimately has the potential to affect a “mother’s developing relationship with her foetus” (1988: 87).

My task throughout this thesis has been to explore women’s experiences of a first time continuing pregnancy over the course of gestation. Rothman’s concept of the tentative pregnancy has helped me to make sense of and describe my participants’ experiences, albeit in different ways and to varying degrees over the course of pregnancy. I argue that my participants’ experiences of pregnancy as tentative relate to two important aspects of their accounts of gestation, discussed throughout this thesis: firstly, uncertainty as related to risk, and secondly, uncertainty with regards their pregnant status and their conceptualisations of the foetus. This I describe in terms of ‘ambiguity’. The following sections consider the role of risk and uncertainty in my participants’ experiences, and of ambiguity in pregnancy. These sections outline how these different dimensions of tentativeness played out for participants over the course of the nine months of gestation. This approach has been enabled by my longitudinal approach to data collection. Examining pregnancy in this way has resulted in theoretical contributions to existing social science literature, which I outline below. The last part of this chapter considers how the qualitative exploration of pregnancy over time, and attention to women’s changing experiences of tentativeness, have shed light on the interplay between forms of knowledge encountered over the course of pregnancy.

7.3 Risk, uncertainty and pregnancy: tentativeness over time

As described in Chapter Two, analyses of pregnancy in existing sociological and anthropological literature are often framed by, and draw on, sociocultural theories of risk (e.g. Lupton, 1999b; Jones, 2007; Rothman, 2014). I suggest that the concept of tentativeness, and the consideration of women's experiences of gestation over time, offer a more nuanced approach to the study of pregnancy in the social sciences.

My participants' accounts suggested that, for them, the first trimester of gestation marked a unique period of pregnancy. This was in terms of their embodied experiences, the development of the foetus, and their relationships with others. My interviewees' conceptualisation of the first trimester as distinct from the remainder of gestation can be related to their understanding that the first twelve weeks of pregnancy entailed the highest probability of a pregnancy loss. The language of risk loomed large in participants' narratives of their first trimester of pregnancy. They described the heightened risk of miscarriage, and viewed the second trimester as the point at which these risks would be reduced. Participants also presented me with calculations of miscarriage risk in the form of statistics. However, I found that it was not risk per se, but the *uncertainty* associated with perceived risks, that better characterised my participants' experiences.

As observed in Chapter Two, the concept of uncertainty is becoming more widely discussed as distinct from, though related to, risk in existing literature (e.g. Zinn, 2008)³¹. It has been defined as a "state of not knowing, and therefore being unable to control" (Reith, 2004: 383). Uncertainty is at the heart of the risk society thesis advanced by Beck (1992) and relatedly by Giddens (1991). These authors describe how what they term (late) modernity (referring to 'post-industrial' society (Beck, 1992: 10)) has created a climate of uncertainty. This is due, for example, to previously unknown threats posed by technoscientific development (Beck, 1992: 22), or to profound changes to accepted states of affairs in the modern era, including family relationships and gender roles (Beck, 1992: 87; Giddens, 1991: 184). Within

³¹ Though it has been a constant presence in science and technology studies, where efforts to transform uncertainty in the production of scientific knowledge, often through simplification, have been explored (see Star, 1989 for a seminal text in this field).

some of this sociological work there is a consensus that the concept of risk is invoked to in some way manage uncertainty. This is by providing a framework for rational action, for example through becoming informed about potential dangers, weighing up probabilities, and protecting against harm (Reith, 2004: 395). Similarly, some authors conceptualise risk assessment as the “statistical prediction” of the future (Reith, 2004: 393; O'Malley, 2008: 72), entailing determinate outcomes (Lyng, 2008: 110), and as such conferring individuals with a degree of control. Giddens has termed such attempts at control, and efforts to “stabilise outcomes” in the face of uncertainty, as the “colonisation of the future” (1991: 133).

Though the portrayal of future events in terms of risk has been described as a means of managing uncertainty, for example through its quantification (Reith, 2004: 386), for my participants, uncertainty remained - or could even be argued to have resulted from - their understanding of first-trimester pregnancy loss in terms of risk. Their knowledge of the risk of early miscarriage (and to a lesser extent foetal abnormality detected at the twelve week scan) created uncertainty as to whether or not pregnancy would result in the eventual delivery of a healthy baby. This understanding of potential loss arose from descriptions of miscarriage rates in early pregnancy, obtained from GPs and pregnancy literature, and was substantiated by women's experiential knowledge of friends and family members who had experienced a pregnancy loss. This placed them in a 'liminal' state, similarly described by Rothman (1988), and hesitant to take the pregnancy's success for granted. However, unlike descriptions of risk as representing a means of managing uncertainty, for example by suggesting possible means to reduce harm, outlined above, discourses of the risk of early pregnancy loss provided women with no means to resolve this. For my participants, the risk of miscarriage during the first trimester was not perceived as one that could to be managed. Some participants, including Marisa and Leila, thus spoke of 'fate', demonstrating the feeling of powerlessness described by women with regards a possible first trimester pregnancy loss. Knowledge of the heightened risk of miscarriage thus created and sustained uncertainty, prompting (but also exacerbated by) a particularly tentative engagement with their pregnancy at this time.

I argue that, in the absence of strategies to address the risk of an early miscarriage, women managed uncertainty through emotion work during their first trimester of pregnancy. This entailed efforts to not get ‘too excited’ about the pregnancy, and withholding news of the pregnancy from others. Their emotion work was not a means of managing the risk of pregnancy loss per se, but a strategy used to live with the uncertainties of whether or not they would reach the end of their pregnancy, and deliver a healthy baby.

As described in earlier chapters and above, risk did feature in participants’ narratives, particularly during the first trimester. However, this fluctuated over the course of pregnancy, with discourses of risk, uncertainty and thus tentativeness with regards the pregnancy’s success shifting in focus, and becoming less often articulated, as gestation continued. After the first trimester, uncertainty with regards a successful pregnancy was at times voiced, though in relation to specific events or time points. For example, the anticipation of the twenty week scan re-introduced the possibility that the pregnancy may not continue, now due to the potential for the detection of a foetal anomaly. Another trigger for some of my participants’ hesitant approaches to later pregnancy was the gradual alleviation of pregnancy symptoms such as morning sickness. This often occurred between their twelve and twenty week ultrasound scans, and foregrounded uncertainty once more (with regards whether women were (still) pregnant). The fact that uncertainty could be introduced as a result of bodily changes demonstrates that not only contact with medical interventions (described in Rothman’s work as the source of tentativeness in pregnancy), but also embodied experience, was able to re-introduce uncertainty with regards the pregnancy’s status.

As well as highlighting the role of embodied experience in constructing pregnancy as at risk or uncertain, my participants’ accounts have further complicated existing literature. For example, whilst the medicalisation of pregnancy has been charged with constructing early pregnancy as at risk, some of my participants described that care provided in this setting at times projected a sense that the pregnancy would inevitably *succeed*. This was exemplified in their provision of stretchmark cream or information on breastfeeding during the first trimester of pregnancy. These acts had

the potential to conflict with women's emotion work, especially regarding their efforts not to think too far into the future, in the face of uncertainty as to whether the pregnancy would continue. The pervasiveness of this disparity between health professionals' perceptions and women's experiences of the first trimester is a potential topic for future research.

By the final round of interviews, overt discussions of risk and uncertainty were rare. For example, only Andrea raised the issue of stillbirth, making sense of this in terms of statistical assessment of probability³². However, during these meetings, which took place at approximately thirty five weeks, tentativeness with regards the success of the pregnancy could, at times, be reintroduced. Again, following the early and mid stages of pregnancy, this tentativeness had changed focus. When voiced, tentativeness related to uncertainty with regards the safety of the foetus (for example, whether it required medical attention). Women could largely apprehend foetal health due to their embodied knowledge of foetal movements, which were often voiced as providing them with reassurance. However, the absence of these movements could reanimate anxieties about having a healthy baby. At times during later pregnancy, concerns with regards the success of the pregnancy could thus again be foregrounded, in accordance with medical discourses encouraging women to seek help should foetal movement reduce.

Though medical advice, for example regarding foetal movements, could re-introduce tentativeness, information and concepts from medical professionals and resources also had the power to resolve this. An important milestone occurring during the later stages of pregnancy - and providing women with reassurance about the likely success of the pregnancy - was the notion of 'foetal viability' (the gestational stage from which a foetus could potentially survive outside of the womb). Participants gave varying accounts of viability, with most describing this as being reached at between twenty four to twenty eight weeks gestation. As described in Chapter Six, the notion

³² My (infrequent) discussions of the birth with participants did not emanate a sense of risk. More often when raised, interviewees talked about this in terms of the medical interventions they were planning to accept or refuse. This may, however, have resulted from the fact that I did not question them about the birth, due to my research focus on pregnancy.

of viability was familiar to participants through its discussion on Internet messageboards, and also in the resources they had received from healthcare professionals.

Women's awareness of this concept had the potential to restore their pregnancy's status as tentative, through the positioning of their foetus as 'not yet viable' *prior* to this point. However, by the time we met at thirty five weeks, I argue that women's understanding of the foetus as able to survive outside the womb had contributed to a reduction in uncertainty with regards the pregnancy's outcome, and thus tentativeness, in two ways. Firstly, participants explained that the point of viability signalled that the foetus had passed its developmental milestones. Some interviewees explained that by this stage, the foetus was "putting on fat" (Marisa, Gail). This understanding resolved some uncertainty with regards their chances of having a healthy baby. Secondly, should anything require women to seek medical attention, such as a reduction in foetal movement, participants explained that they had a favourable chance of giving birth to a live baby. Several interviewees noted that should this occur, medical professionals would assist a baby's survival, due to it having reached the developmental milestone of viability. Making it to this stage again indicated to these women that they would have a healthy baby. Accordingly, women did not experience their pregnancy as tentatively as they had prior to this point, and most no longer described engaging in emotion work, for example, by suppressing feelings of excitement. Indeed, a quote from Sinead is suggestive of how a reduction in tentativeness contributed to her understanding of the foetal entity as (almost) a baby during our last interview, in which she explained "as the risks diminish, and the, and the potential heartache of losing something reduces, it becomes more of a baby".

I have demonstrated in this section that my participants articulated a sense of tentativeness throughout pregnancy, which shifted in intensity and focus over time. My focus has been on uncertainty as related to risk, which I view as a key element of the tentativeness my interviewees experienced. I have argued that though risk was a prominent aspect of women's accounts, particularly during early pregnancy, my

interviewees' actions in terms of emotion work at this time were not to address risk per se (which was not seen as able to be managed), but to address the uncertainty associated with discourses of early pregnancy loss. This uncertainty, placing women in a 'liminal' position, at times did not allow women to fully embrace their pregnancies, instead resulting in them engaging with pregnancy tentatively, as Rothman (1988: 101) describes.

The next section explores another facet of participants' tentativeness during pregnancy: ambiguity. I largely discuss this in relation to women's experiences of embodiment, which again contributed to the shifting nature of tentativeness over time. The section also draws on changing conceptualisations of the foetus.

7.4 Pregnant embodiment: From ambiguity to absence

As described in Chapter Four, participants' bodily experiences during the first trimester were characterised by ambiguity. Though conceptually related to the notion of uncertainty, here I use ambiguity to refer to the possibility for a phenomenon to be understood in two or more ways (Stevenson, 2015). For example, during their first trimester, my interviewees' comparison of morning sickness with generic 'illness', and the absence of known signs of pregnancy (most notably a bump), contributed to the fact that many did not easily identify themselves as being pregnant. This meant they were positioned in a liminal state, between being a pregnant and non-pregnant woman. Alongside the risk and uncertainty characteristic of early gestation, I argue that this doubt with regards their pregnant status contributed my interviewees' hesitant acceptance of, or what Rothman describes as a "commitment" to, their pregnancy (Rothman, 1988: 101).

As I have described above, the majority of my participants less often expressed experiences of tentativeness as they moved through gestation. This was linked to my interviewees feeling more certain about the safety of the foetus, and success of the pregnancy. Yet, feelings of certainty related not only to decreased anxiety, but also the fact that women's embodied experiences were no longer ambiguous. By the time we met at approximately thirty five weeks, the shifting and stretching sensations felt

by participants could be clearly identified as foetal movements. This contrasted with the sensations felt by many during mid-pregnancy (at approximately seventeen to twenty weeks), which interviewees found difficult to distinguish from the digestive movements caused by their own bodies. Further, by late gestation their bodies had taken on a pregnant shape, recognisable as such due to my participants' common sense knowledge (Schutz, 1953) of pregnancy. These elements of embodied certainty, then, contributed to a reduction in women's tentativeness in later pregnancy.

My participants' accounts of their changing corporeality over the course of gestation also contribute to literatures on embodiment. Though scholars have sought to destabilise the dualistic conceptualisation of the mind as distinct from the body (e.g. Merleau-Ponty, 1962), my participants at times described their embodied experiences of pregnancy in precisely those terms (as have participants in existing work in this field (e.g. Carter, 2010)). This was through descriptions of, for example, uncharacteristic behaviour during early pregnancy, which Deborah and Ingrid attributed to their changing hormones. At the same time, I noted that the experiences some participants described to me pointed to the *inseparability* of the body and mind. This was particularly apparent in Andrea and Eve's narratives, with Andrea describing in our first meeting that she was "in tune with [her] body", and Eve saying that she felt "more connected to [her] body" in our final interview. These accounts do, nonetheless, maintain a conceptual distinction between the body and the mind.

As described in Chapter Two, Leder (1990) attributes the persistence of mind/body dualism in 'Western' thought to the fact that the body is rarely the object of experience. He argues that this allows for the possibility of its neglect, due to the fact that it is rarely the focus of our attention (1990: 69). Pregnancy is generally described in academic literature as a time when a woman has a greater awareness of her body (Young, 1984; Tyler, 2000). It has thus been drawn on to dispute Leder's claim that the body is available to consciousness only during periods of "dysfunction", such as pain (1990: 70).³³ The accounts of my participants, however,

³³ Including by Leder himself (1990: 186)

at times laid challenge to the notion of the body as perpetually ‘present’ during pregnancy. In Chapter Six, some of my interviewees described episodes of bodily absence. This included participants not noticing the changes occurring to their bodies, which were experienced as gradual, until visualising this in photographs (Ingrid, Andrea). Such absence even occurred during later pregnancy when changes to their bodies were most evident, to themselves and others. Though at times foetal movements could be experienced as “violent” (Sinead), and “distracting” (Keira), these could also at times fade into the background for participants. This prompted some to reflect on how many times, or even whether at all, they had felt foetal movements that day, in line with NHS guidance regarding foetal activity. Here, tentativeness with regards foetal health could be re-introduced at times when movements were not apparent. It was thus periods of bodily absence, and not presence, that signalled ‘dysfunction’ for participants, contrasting with Leder’s (1990) original description of the ‘absent body’. As described in Chapter Six, this posed challenges to participants’ abilities to monitor the foetal movements they were experiencing. Guidance in this regard therefore did not always seem to resonate with participants’ lived experiences of foetal movements. That the foetus was sometimes ‘absent’, i.e. not always brought to attention, may indicate that women experienced their bodies and the body of the foetus as (at times) interconnected. This has implications for understandings of the foetus as an independent subject.

Feminist discussions have demonstrated how the conceptualisation of the foetus as an autonomous individual or baby may be mobilised to limit women’s reproductive freedoms, most obviously their decisions regarding abortion (e.g. Petchesky, 1987; Zechmeister, 2001). Many authors have attributed the ability to conceptualise the foetus as autonomous to the introduction of visualising technologies into pregnancy, in the form of routine ultrasound scanning (Taylor, 1998; Han, 2008). The development of foetal photography (Stabile, 1992) and the commodification of foetal images (Taylor, 1992; Morgan, 2011) have also been seen as contributing to this understanding of foetal entities. In a bid to destabilise the notion of foetal subjectivity, and (re)position women at the centre of their pregnancies, some scholars have therefore proposed alternative ways of conceptualising the foetus (Conklin and

Morgan, 1996; Morgan, 2002). One means is through an extension of academic discussions to the intercorporeality of pregnancy, through a focus on the placenta, and more recently, the phenomenon of maternal-fetal microchimerism (Hird, 2007; Kelly, 2012). Amid these moves to reconceptualise the maternal-foetal unit, Roberts (2012) points to alternative means of disrupting the notion of foetal autonomy. Her work on ultrasound outlines the challenges posed to feminist discussions of the foetal subject by women's enjoyment and active pursuit of foetal images. Remaining mindful that experiences of the foetus as person, and of bonding, hold important meanings for women, Roberts suggests that a way forward for feminist analyses may be to make room for different experiences of ultrasound, "including more ambivalent responses" (Roberts, 2012: 89). I venture that this approach to destabilising the foetal subject, and thus re-focusing women as the subjects of their pregnancies, might also be extended, for example, to experiences of pregnancy more generally which do not seem to accord with a view of the foetus as 'person'.

For example, for interviewees, the ambiguity of the foetus was evident during early pregnancy. Some participants described conceptualising the foetus not in terms of a 'person' or 'baby', but in terms of an "egg" (Eve), or a "balloon" (Keira). In their reflections on a possible miscarriage, Deborah, Gail and Nancy explained that at this time they would conceptualise the loss in terms of a potentiality, or as Gail described it, a "failed attempt to conceive". Even in the case of ultrasound, which as outlined above has often been charged with contributing to an understanding of the foetus as person (e.g. Petchesky, 1987; Han, 2008), for some interviewees this technology further constructed the foetus as ambiguous. This was through the production of foetal images that women regarded as alien or ghostly. Participants' experiences, then, did not always implicate imaging technologies in the construction of the foetus as 'their baby'. This has also been described in the accounts of women acting as gestational surrogates (Roberts, 1998; Teman, 2010).

Later in pregnancy, embodied experiences such as definite kicks, and for some the identification of a personality through these, allowed for a less tentative approach to their conceptualisation of the foetus, which many had begun to talk about in terms of

a future baby. However, though no longer an ambiguous entity in itself, the positioning of the foetus in relation to my participants' bodies remained largely difficult to articulate, with few being able to clearly discern the foetus as separate from themselves. For some, this stemmed from their awareness that the foetus was connected to them in some way, highlighted by its kinetic responses to food or drink they consumed. A commonality amongst the majority of my participants, and key finding of this research, is that the concept of viability proved pivotal to several women's understandings of the foetus as a separate entity, and for some towards their conceptualisation of the foetus as person.

It was through their appropriation of the medically-situated concept of viability, coinciding with regular and recognisable embodied signs of foetal health, that participants' experiences of the foetus became noticeably less ambiguous, and thus less tentative. Although viability solidified the foetus' status as a (future) baby for some, the analysis presented in this thesis also suggests that the foetal entity as conceptualised by my participants was unlike the unproblematic 'foetal subject' depicted in popular culture, and challenged in existing feminist literature. The foetuses carried by my participants were experienced as ambiguous, absent, separate, connected, and sometimes as babies: variously shifting between these, and sometimes simultaneously (see also Schmied and Lupton, 2001; Lupton, 2013b). These flexible and variable understandings have surfaced through my exploration of women's experiences of pregnancy *over time*. These fluid beings do not mirror the entities defined in existing literature, outlined in Chapter Two, with which pregnant women are expected to form a 'bond'. My thesis has thus problematised clinical studies which purport to be able to measure women's feelings of attachment to 'the' foetus using cross-sectional scales. Indeed, for my participants, the notion of such a bounded entity within them was impermanent, shifting between presence and absence, and separateness and connectedness.

This chapter has demonstrated how women's experiences of uncertainty with regards the safety of (or risks to) the pregnancy, and also their ambiguous experiences of their pregnant bodies and the foetal entity within, both contributed to women's

experiences of pregnancy as tentative. As women's experiences of uncertainty as related to risk, ambiguity, and thus tentativeness, changed over time, so too did their interactions with the various forms of knowledge available to them during pregnancy. These changes are described in the following section.

7.5 Knowledge, expertise and pregnancy

Biomedical depictions of pregnancy often featured in my participants' accounts as shaping their experiences. Broadly, women experienced early pregnancy as particularly tentative, in line with discourses of miscarriage risk, and in later pregnancy felt more certain with regards the safety of the foetus, echoing medically-situated definitions of foetal viability. This might be interpreted as demonstrating my interviewees' internalisation of a 'biomedical framing, or 'biomedical model' of pregnancy (see Nash, 2012b; and Neiterman, 2013 respectively). It is important, however, to understand their engagements with biomedical discourses as complex and negotiated (see also Lippman, 1999b; Markens et al., 2010), and also as shaped by experiential and embodied knowledge.

This thesis has shown that participants' interactions and judgements with regards the knowledge derived from biomedical sources shifted over the course of gestation. In early pregnancy, women frequently engaged with advice received from health professionals, tracked the development of the foetus through daily or weekly updates on foetal growth, and sought additional advice with regards the consumption of certain foods. Thresholds such as that of the first trimester, and resources portraying how participants 'should' be feeling, heavily framed my participants' accounts. However, I do not suggest that women *necessarily* privileged biomedical depictions of pregnancy, or saw them as authoritative (cf. Jordan, 1978; Davis-Floyd and Sargent, 1997). Instead, I interpret their narratives as signalling that medical understandings of pregnancy held the most value or 'relevance' (Murphy, 2003) for women *at this time*.

During early pregnancy, women's embodied experiences were uncertain, and due to adherence to the 'twelve week rule' of secrecy, their pregnancies were not known to

their wider social networks. Women did have, however, a stock of empathetic experiential knowledge, which for many included the pregnancy losses of family and friends (and in Andrea's case, her own). It was in this context that women's interactions with medical knowledge were situated. At this time, messages from medical sources frequently transmitted discourses of the vulnerability of pregnancy, and risk of pregnancy loss. I argue that the persuasiveness of these messages cannot be attributed (solely) to their source, but the fact that these messages concurred with their ambiguous bodily experiences, or "corporeal uncertainty" (Nash, 2012a: 43). Wynne (1992) explains that social relationships, interactions and interests shape individuals' responses to scientific information. These influence the trust and credibility individuals are prepared to invest in such messages (1992: 282). As medical discourses of risk and uncertainty accorded with women's embodied experiences, as well as their empathetic experiential knowledge, I argue that women ascribed them with particular weight at this time, in line with their judgement of these as credible. Attributing credence to medical messages regarding miscarriage thus contributed to, but was also shaped by, their experience of the first trimester of pregnancy as particularly tentative. This was not to say, however, that participants accepted all aspects of medical knowledge regarding pregnancy during this period. Indeed, though Gail explained the influence of medical discourses of age and fertility on the timing of her pregnancy, she later questioned the advice she received regarding the avoidance of runny eggs during pregnancy, deciding to apply what she described as "common sense" to this guidance.

By the time participants had reached their final trimester, discourses of the riskiness of pregnancy were no longer experienced by women to be as credible (and, indeed, were encountered less frequently). I attribute this to their changed, and now certain, embodied experiences. Medical assessments of the pregnancy, which in early to mid-gestation had taken the form of the ultrasound scan or the Doppler machine, described in Chapter Five, became less valuable, due to the fact that participants now experienced regular foetal movements. As described in Chapter Six, this therefore lays challenge to the assertion that women's embodied experiences have become

devalued by technological intervention in pregnancy (e.g. Rothman, 1988; Duden, 1992).

At this stage participants welcomed the fact that their midwife appointments were less frequent, and had begun to question some of the advice or recommendations they received. However, again I do not claim that participants thus accepted their embodied knowledge as wholly authoritative. Indeed, an important aspect of their eased anxieties during later pregnancy was the concept of viability. This concept was interpreted in tandem with women's embodied experiences. Daily foetal movements, and the change in these from 'kicks' to 'shifts' or 'stretches', indicated that the foetus was steadily growing. In line with discourses of viability then, these experiences signalled to women that the foetus had completed the majority of its development.

Murphy's (2003) discussion of women's experiences of breastfeeding has outlined comparable shifts in what she describes as the perceived 'relevance' of technical expertise (from midwives), to the practical expertise developed by women during their own encounters with breastfeeding. However, this thesis departs from Murphy slightly in that I have underscored how knowledge derived from medical and embodied sources interacted in "complex and synergistic" ways (cf. Markens et al., 2010: 39). As introduced in Chapter Six, it is thus problematic to see knowledge derived from varying sources, for example medical and embodied knowledge of pregnancy, in terms of two distinct and bounded sets of discourses and practices. Indeed, any boundaries between the two are blurred in practice, and difficult to delineate. As demonstrated by my participants, their engagement with medically derived statistics regarding miscarriage, for example, were experienced as so pervasive in line with their experiential knowledge.

Additionally, like Markens et al. (2010) (see also Markens et al., 1999; Root and Browner, 2001), I do not conceptualise incidents of the refusal of specific biomedical advice or procedures by my participants (e.g. Heather, Gail) as demonstrating the rejection of, or resistance to, biomedical advice and techniques in general. I instead

interpret such decisions as responding to the value or ‘relevance’ (Murphy, 2003) placed on different sources of knowledge at particular times or in particular contexts within pregnancy. The value placed on varying sources of knowledge was often reflective of their experiences of pregnancy as more, or less, tentative. For example, as outlined in Chapter Five, some participants particularly valued the heartbeat Doppler machine when offered to them at sixteen weeks. This was due to its use at a time when the embodied symptoms of early pregnancy had waned, an experience which had reintroduced uncertainty with regards the pregnancy’s outcome. The Doppler machine provided one of the few means of reassuring women of the foetus’ safety at this time. Later in pregnancy, however, the knowledge provided by the Doppler had become devalued as women’s embodied experiences were able to provide regular knowledge of foetal health.

For many, movements were the most significant aspect of pregnancy, providing constant reassurance, but also a means of ‘getting to know’ the foetus, for example through its patterns of movement. However, as discussed, some interviewees later turned to technology to provide them with knowledge inaccessible through embodied means, such as the facial features of the foetus. My interviewees thus engaged pragmatically with various forms of knowledge, and their corresponding techniques.

So far, this chapter has outlined experiences of tentativeness as described by my participants, and their accounts of uncertainty and ambiguity. The concept of the tentative pregnancy had resonance particularly in the early weeks, and at times during later pregnancy. I have also described that as experiences of pregnancy as tentative shifted over time, so too did women’s interactions and valuations of various sources of knowledge. In the next section, I describe implications of mobilising the concept of tentativeness for social scientific discussions of pregnancy.

7.6 The tentative pregnancy re-visited

This thesis has demonstrated the value of Rothman’s (1988) concept of the tentative pregnancy to making sense of women’s accounts of first time pregnancy in a contemporary UK context. All of my participants at some stage made reference to

uncertainty associated with discourses of pregnancy as ‘at risk’, and to ambiguity, in terms of their embodiment or conceptualisations of the foetal entity. This resulted at times in a hesitancy to take the success of the pregnancy, or birth of a healthy baby, for granted.

Rothman’s participants experienced their pregnancies as tentative as a result of their contact with medical intervention in the form of diagnostic testing, which introduced the possibility that their pregnancy may not end in a baby. The majority of my participants, however, conceptualised their pregnancies as tentative merely by virtue of being pregnant. This was largely expressed in the first trimester, due to particular uncertainty relating to the pregnancy’s success. The surety brought by their embodied experiences, and reduced perceptions of risk to the pregnancy, meant that tentativeness rarely characterised accounts by the time women had reached their final trimester. It did, though, re-emerge in accordance with particular events or periods of gestation, as outlined above.

Experiences of the tentative pregnancy were perhaps articulated in different ways by the participants in this research, when compared with those in Rothman’s (1988), because they did not engage with the procedure forming the focus for Rothman’s work: amniocentesis. It may also be due to my interviewees’ situation in a contemporary UK context. Here, despite the fact that existing literature (described in Chapter Two) describes a silence surrounding miscarriage, discourses of risk regarding the *potential* for a pregnancy loss during the first trimester are readily available to women. These were communicated to my interviewees by health professionals, through their knowledge of the pregnancy losses of family and friends, and their use of the Internet. Nettleton (2004) describes that the latter represents the ‘e-scape’ of medical knowledge from the confines of medical institutions, and into arenas where it can be assessed and potentially re-appropriated. For my participants, this re-appropriation served to further legitimate biomedical discourses of miscarriage risk, which were also informed by their empathetic and experiential embodied knowledge. Knowledge of and adherence to the ‘twelve week rule’, a public secret (Taussig, 1999) communicated within social networks, but also in the

NHS resources provided to women, has also contributed to this. The tentativeness described in Rothman's work may thus today be encountered by a much larger group of women than those she describes, who were offered amniocentesis through medical professionals, and only if designated as 'at risk' by factors such as their age. In the UK today, discourses of miscarriage risk may be known to women (and their social networks) before they have even become pregnant³⁴.

A marked difference between the tentative pregnancy of the contemporary UK context, and that described by Rothman, then, is that today, tentativeness has been extended backwards into early, and in some cases pre-pregnancy (demonstrated in my interviewees' tentativeness with regards conception). That women are able to experience particular tentativeness during early pregnancy is of course due to the fact that today women can test for a pregnancy from one to two weeks post-conception, with these tests readily accessible over the counter. During the first trimester, my participants rarely discussed tentativeness in terms of prenatal tests (they would not receive the results of their initial blood tests, occurring at the eight week booking appointment, until after their twelve week scan (see Appendix I)). Instead, in line with their experience of the first trimester as particularly tentative, my interviewees were reluctant to think this far into the future.

As also described in Rothman's (1988) work, though specific interventions such as prenatal diagnostic tests also had the ability to re-introduce tentativeness, these were largely seen by participants as simultaneously providing reassurance (in the case of favourable results). The first trimester for my interviewees, however, was characterised by a relative lack of medical intervention. My fifteen early interviews, conducted during the first trimester of pregnancy, have allowed for exploration of this early period of gestation. They indicate that perhaps this lack of access to (hoped for) reassurance from medical professionals also contributed to tentativeness, thus adding another dimension to Rothman's concept. Some women at times voiced a

³⁴ I have not been able to find any critical public health literature discussing whether discourses of early miscarriage from public health sources have become more prevalent in the contemporary era. This has been the case, however, for materials encouraging the protection of the foetus through maternal behaviours (Lupton, 2012). This perhaps signals a different conceptualisation of the foetal entity lost through miscarriage, to that in a continuing pregnancy, also articulated by my participants.

stronger sense of bearing the responsibility for the pregnancy at this stage, having not shared their news with others, and of welcoming becoming part of a 'system' of care. Again, the early home testing available to women in the contemporary UK has shaped these experiences. So too has the fact that my participants' antenatal care was readily accessible, being provided free at the point of need, which again marks a departure from the context of Rothman's research.

As theorised by Rothman, my participants' experiences of pregnancy as tentative seemed to shape their emotional engagement with the foetal entity within. As described in Chapter Four, owing in part to their resistance to thinking too far to the future, participants did not describe the foetus within in terms of an entity to which they could form an emotional attachment, or 'bond', with. This only arose, and only for some participants, later in pregnancy. I argue that this was allowed for due to a reduction in tentativeness with regards a successful pregnancy and birth of a healthy baby. For my participants, this came largely in mid- to late- pregnancy, a result of their engagement with medical discourses of viability, but also of the embodied experiences of foetal movements.

My study has contributed to existing work on the tentative pregnancy by exploring the techniques used by my participants to manage this hesitant approach to their pregnancy, particularly in early gestation. Mobilising Hochschild's (1979) concept of emotion work in Chapter Four has allowed me to make sense of participants' strategies to regulate their emotions during the first, most tentative trimester of pregnancy. My description of their efforts to keep the pregnancy a secret at this time has also added to literature in this field. Additionally, my thesis has described the shifts in interviewees' experiences of the tentative pregnancy over the course of gestation, and outlined their relation to the concepts of risk and uncertainty, and ambiguity. I have described how these were shaped in multiple ways for participants, including through their embodied experiences, empathetic experiential knowledge and medical discourses of risk. Finally, I have described, particularly in Chapters Five and Six, the consequences of women's experiences of pregnancy as tentative for their conceptualisations of and engagement with the foetal entity.

7.7 Conclusion

This chapter has described the contributions made by my thesis to existing literature regarding pregnancy in the social sciences. It has added to existing discussions of risk and uncertainty in pregnancy, to understandings of pregnant embodiment and the ‘foetal subject’, and of women’s interactions with various forms of knowledge at this time. My work has also demonstrated the relevance of Rothman’s (1988) concept of the ‘tentative pregnancy’ to making sense of women’s accounts of a first time pregnancy in a contemporary UK context. Finally, I have added to existing discussions of the tentative pregnancy by demonstrating how my interviewees managed tentativeness: for example, through emotion management, managing social interactions, and seeking reassurance. The next concluding chapter considers the implications of this work for future research.

Chapter Eight

Conclusion

8.1 Introduction

This thesis aimed to explore women's experiences of 'ordinary' (cf. Han, 2013) pregnancy over time, including a focus on the first trimester. This is a period of gestation often neglected in existing literature. Following three chapters exploring my data, Chapter Seven discussed how the exploration of fifteen women's experiences of a first time pregnancy, at three time points over the course of gestation, has contributed to existing literature in this field. In particular, I have shown how Rothman's concept of the tentative pregnancy has been invaluable to make sense of my participants' experiences of a first time pregnancy. This brief concluding chapter offers a reflection on the implications of my research, and also suggests areas for future investigation. These, however, must be approached with an awareness of the limitations of my study, which I outline below.

8.2 Methodological issues of note

The women interviewed for this research were experiencing the same category of what could be described as medically uncomplicated, first time, and (as much as is possible to know) 'planned' pregnancies. My sample thus cannot be said to be representative of all women experiencing pregnancy in the UK. Nevertheless, my interviews and analysis have allowed for exploration of the diversity of experiences within the category of 'ordinary' pregnancies, warranting a degree of conceptual generalisability. The small sample size was necessitated by my use of repeat interviews, and the limited amount of time available to me for data collection. My approach in this regard has facilitated in-depth exploration of women's experiences *over time*, an important consideration missing from many existing accounts of pregnancy. Re-visiting women enabled the observation of the fluidity of women's experiences throughout the course of gestation. Meeting women as they experienced changes, or shortly after engaging with various interventions, more readily allowed

for accounts which at times challenged dominant cultural narratives, for example with regards the ultrasound scan (see also Beynon-Jones, 2014).

Though a small sample size was required for me to conduct longitudinal interviews in the time available to me, this also facilitated my analytical approach. When working with my data, an iterative process requiring me to become very familiar with my participants' accounts, my methods ensured that my interviewees' voices were foregrounded. The circumstances and key events surrounding each interviewee's pregnancy remained distinct in my mind throughout the process of analysis and writing, which in this thesis were intertwined. This would have been difficult to achieve with a larger number of participants. Meeting with participants more frequently may also have hindered the in-depth consideration given to interviews. My choice of meeting with participants three times was further influenced by my desire not to overly-intrude on their already busy lives.

The small and relatively homogenous sample used in this study has meant that the voices of other groups of women have not been represented. Indeed, Coxon (2014) laments the fact that research on experiences of pregnancy often focuses on those who are socioeconomically advantaged, and of limited ethnic diversity. Those becoming pregnant during their teenage years or early twenties, an experience often associated with socioeconomic status in the UK (Arai, 2003), may pose challenges to my findings. Those of my participants aged over thirty five, an age over which adverse pregnancy outcomes are said to increase (Laopaiboon et al., 2014), described their experiences of tentativeness in similar ways to those interviewees in their twenties and early thirties. Nevertheless, it would be beneficial to explore the experiences of both these groups of women further, through longitudinal interviews with women in their teenage years, and with a larger number of those over thirty five. Women from less, or very much more, affluent backgrounds may also provide different accounts. This social determinant has been described in relation to desired levels of control during birth (Lazarus, 1997), and also views with regards prenatal diagnostic testing (Browner and Preloran, 2000) in accounts from the United States. The UK context for my research, entailing the provision of antenatal care free at the

point of need, was a key factor in participants' engagement with medical interventions, and their accompanying discourses of risk. How this shaped women's experiences of pregnancy as tentative may be illuminated through the exploration of those with restricted access to healthcare, or in contrast, those obtaining healthcare privately. The following discussion must therefore be considered with these caveats in mind.

8.3 Ways forward

The exploration of fifteen women's experiences of a first time pregnancy over time, and my mobilisation of the concept of the tentative pregnancy, have both complicated and made contributions to existing literature. Chapter Seven distinguished my use of the term 'uncertainty' from the notion of 'risk'. The latter is commonly drawn upon in social scientific discussions of pregnancy (as described in Chapter Two). Coxon (2014) argues that the frequent analytical treatment of pregnancy in terms of sociocultural theories of risk may limit our ability to see beyond these. My use of the notion of 'tentativeness' represents a way of conceptualising pregnancy beyond risk, whilst also maintaining risk as *a* topic of study. The concept of tentativeness allows for a more nuanced understanding of women's experiences of risks to their pregnancy by more explicitly incorporating the concepts of uncertainty and ambiguity.

This thesis has highlighted several areas for further research. Firstly, I have demonstrated the utility of the notion of 'emotion work' for making sense of women's experiences of pregnancy, being most evident during the first trimester as a mode of managing uncertainty. In relation to pregnancy, the concept has previously been discussed in the context of the emotional labour performed by midwives, in line with Hochschild's (1983) use of the term in relation to paid work (e.g. Hunter, 2005). However, recent research has described how women may perform emotion management in later pregnancy and birth, for example, to cope with negative events or manage pain (Carter and Guittar, 2014). An examination of emotion management over time, then, may shed further light on the concept's relevance throughout pregnancy, and contribute to lessening the impact of any emotional work on

women's wellbeing at this time. As Hochschild (1983) has outlined, emotion management may entail physical, as well as psychological consequences for individuals. I have also described how, for some participants, healthcare professionals posed challenges to emotion work, for example by discussing a future baby in the early weeks of pregnancy. If my participants' experiences are representative of others experiencing pregnancy, women's engagement with maternity care may be enhanced through increased sensitivity to the anxiety women experience, and the strategies they use to deal with this particularly liminal phase.

The potential of mobilising the concept of emotion work to describe the management of uncertainty has also been pointed to in the field of chronic and (potentially) terminal illness. Existing literature has outlined techniques used by healthcare professionals when communicating with patients, but also encouraged in patients themselves. These have been described with reference to the refrain "prepare for the worst, but hope for the best" (Back et al., 2003; Spathis and Booth, 2008). This description of emotion management resonates with my participants' tentative emotions during early pregnancy. Attention to the emotion work potentially employed by these patients may facilitate healthcare professionals in the delivery of sensitive communication at this time.

Viability was a concept known to all of my participants, and represented an important stage of their pregnancy. The resources provided to them by the NHS contributed to this perception. However, little research exists in this area. Further exploration of women's understandings of this point in pregnancy, a time interpreted by participants to signal the safety of the foetus' health, would shed light on whether this perception remains in other contexts; for example, in those who have used assisted reproductive technologies, or engaged with amniocentesis. Though the concept provided reassurance and was welcomed by my participants, it is unclear how the notion of viability is more generally experienced by women, and what the implications of this are for women's understandings of survival following a premature birth, and their health-related practices during later pregnancy.

As introduced in Chapter Two, discourses of a maternal-foetal bond are now commonplace in the resources provided to women during pregnancy, including *Ready, Steady, Baby!* (NHS Health Scotland, 2012). It is important to be mindful of the contribution these discourses make to ideological constructions of motherhood and womanhood. As Eyer (1992) has noted with regards the notion of mother-infant bonding, notions of bonding as a ‘natural’ and expected process may also entail feelings of guilt or failure for women who do not experience this. Though discourses of ‘prenatal attachment’ (Han, 2013), and the notion of ‘parenting’ during pregnancy (Lee et al., 2010) have become more prevalent, the experiences of my participants indicate that the status of the ‘baby’ to which they are thought to attach may be ambiguous. Consideration of women’s experiences of a bond (or its absence) with the foetus may inform future research in this area in clinical fields. So far such studies have linked the (potentially problematic) concept of prenatal attachment, measured using quantitative scales, to health behaviours (Lindgren, 2001), and also postnatal attachment between a mother and child (Siddiqui and Hagglof, 2000).

Extending discussion beyond women themselves, research has begun to explore how pregnancy is experienced by expectant fathers (Draper, 2003) and female partners (Mamo, 2007b). The accounts of prospective grandparents in relation to the sharing of news of a pregnancy (Cunningham-Burley, 1986), and viewing the ultrasound scan (Harpel and Hertzog, 2010) have also been described. Examining conceptualisations of the foetus held by women’s families, and parallel experiences of tentativeness, may provide insights into incorporating these wider networks into the care provided to women during pregnancy. It may also facilitate the provision of support to these individuals, if necessary, in the case of a pregnancy loss.

Finally, the concept of tentativeness as used in this thesis, incorporating uncertainty as related to risk, but also ambiguity, may have relevance beyond experiences of pregnancy. Understandings of pregnancy as tentative influenced and were influenced by my participants’ embodied experiences. These moved from being ambiguous and a source of concern, to almost being unnoticed, over the course of gestation. Tentativeness also shaped the extent to which my interviewees saw corporeal

experience as providing legitimate knowledge of the pregnancy's condition, and their attribution of expert status to health professionals. How tentativeness is lived out and managed by individuals in other situations characterised by uncertainty, for example those experiencing chronic illness (Little et al., 1998) or infertility (Allan, 2007), represents a potential area for further study. This may shed light on individuals' perceptions and engagements with various sources of knowledge, but also the emotional strategies employed by individuals, to manage situations characterised by tentativeness.

8.4 Final reflections

This thesis has demonstrated that pregnancy cannot be understood as a singular event. As shown throughout my chapters, participants described very different experiences throughout their nine months of gestation. My consideration of gestational time has highlighted the ebbs and flows of pregnancy - of shifting embodied experiences and emotions, but also of changing perceptions of risk and uncertainty in pregnancy, and conceptualisations of the foetus. Importantly, this thesis has demonstrated that the foetus, as a material-semiotic actor (Haraway, 1991b), was constituted for participants through their experiences of diverse discourses and artefacts, as well as by the biological itself. I have also shown that the contexts surrounding women's engagement with various medically-situated interventions during pregnancy can shape their experiences of these in varied and sometimes unexpected ways. This underscores the importance of attention to how societies represent, articulate and engage with pregnant bodies, and of continued sociological and political attention to experiences of pregnancy, including those initially viewed as mundane.

Appendices

APPENDIX I

Minimum antenatal care and risk assessment offered during pregnancy

Adapted from *Pathways for Maternity Care* (NHS Quality Improvement Scotland, 2009: 11)

Visit	Weeks	Care
1	As soon as possible	<ul style="list-style-type: none"> - Perform initial risk assessment – e.g. has there been a previous genetic abnormality? Is the patient being treated for a long-term physical condition or a mental health condition? - Provide information regarding screening tests.
2	8-12	<ul style="list-style-type: none"> - Maternal history taking (My participants experiences indicated that this and the above appointment were often combined. They described this as the 'booking appointment').
3	15-16	<ul style="list-style-type: none"> - Fundal height, blood pressure and urine test. - Discuss and document results from screening tests.
4	22-25	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being. - Discuss and document results from screening tests.
5	28	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being.
6 (if first pregnancy)	31-32	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being.
7	34-36	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being. - Assess foetal position, palpate abdomen to assess engagement of foetal head. - Discuss latent phase of labour.
8	37-38	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being. - Assess foetal position, palpate abdomen to assess engagement of foetal head - Discuss membrane sweep

9 (if first pregnancy)	39-40	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being. - Assess foetal position, palpate abdomen to assess engagement of foetal head -Offer membrane sweep if over 40 weeks -Discuss induction of labour
10	41	<ul style="list-style-type: none"> - Take measurements according to handheld maternity record ("blue folder"). These include height of uterus, blood pressure, urinalysis, foetal heartbeat. - Ask women for information according to handheld maternity record: feeling foetal movements? Experienced swelling? Emotional well being. - Assess foetal position, palpate abdomen to assess engagement of foetal head. -Offer membrane sweep. -Discuss induction of labour. <p>If birth has not taken place by 42 weeks, transfer to maternity care team</p>

APPENDIX II
Poster developed to advertise study



Are you pregnant?

Would you like to discuss
your experiences of
pregnancy?

I am a PhD researcher based in the Centre for
Population Health Sciences at the University of
Edinburgh.

**I would like you to take part in my research if you
are:**

- Experiencing your first pregnancy
- In the first 12 weeks of pregnancy and/or have not yet
had your first scan

This will involve:

- Taking part in 3 one-to-one informal interviews with me
over the course of your pregnancy (approximately 1 hour
each)
- Discussing your experiences of pregnancy and feelings
about being pregnant.

**If you would like to participate in this research and
are:**

- over 18 years of age
- located in Edinburgh or 2 hours travelling distance from
Edinburgh

please contact Emily for further information at:

Pregnancy.study@ed.ac.uk or facebook page:
www.facebook.com/edinburghpregnancystudy



APPENDIX III

Mumsnet post (text also used for other forum posts)

Doctoral research - seeking participants in south Scotland/borders to take part in interviews about your experiences of pregnancy (11 Posts) [Recommend](#) [Tweet](#)

MEDIA: Emily R Mon 12-Nov-12 13:10:41

[Add message](#) | [Report](#) | [Message poster](#)

Hi, I am Emily, a PhD researcher at the University of Edinburgh. I am looking for interviewees to take part in my study.

I would like to speak to women experiencing their first pregnancy who have not yet had their first scan (in the south of Scotland/borders area). My research is investigating women's experiences of pregnancy, especially of the growing baby. I would like to interview women three times over the course of pregnancy, once in each trimester, to consider how their changing bodies and encounters with health professionals shape their experiences of pregnancy and the baby. It will be very informal, and a chance for women to share their stories in confidence with a very eager listener. I will also provide refreshments. Each interview will take around 1 hour.

I think that it is going to be difficult to find women in the early stages of pregnancy, so please consider participating, or alternatively spread the word! I realise that the early stages of pregnancy can be a sensitive time, and have procedures in place to account for this. My research has been approved by the Research Ethics Committee in the Centre for Population Health Sciences, University of Edinburgh.

Please email me to take part or for more information, or visit my website:

pregnancy.study@ed.ac.uk

www.edinburghpregnancystudy.wordpress.com

Thank you! Looking forward to hearing from you. From Emily

APPENDIX IV

Image of my study website (used during recruitment)



APPENDIX V

Information leaflet (presented to participants prior to first interview)



'Exploring experiences of pregnancy' PhD Study: Participant Information Sheet



I would like to invite you to take part in an interview study considering how women relate to and understand the relationship they might have with their baby during pregnancy. If you decide to take part in this study, it is important that you are aware of what is involved in my research, and why it is taking place. Please read the following information, and discuss it with your friends or family if you wish to. Please feel free to contact me using the details provided if anything is unclear, or if you have any additional questions.

Why have I been asked to take part in this research?

I am conducting research for my PhD project at the University of Edinburgh. My PhD research will focus on women's experiences of a relationship with their baby during pregnancy. I am seeking women who are in approximately their tenth week of pregnancy to take part in three interviews over the course of the nine months of their pregnancy.

What is the purpose of this research?

These interviews will focus on women's experiences of their changing bodies, their interactions with health professionals, and their awareness of their baby during pregnancy. This will provide me with information about how women feel about their baby and their pregnancy, and will form the basis of my PhD research.

How will the research be conducted?

I will be conducting one-to-one interviews in Edinburgh and the surrounding area with women who are pregnant. Participants will choose to take part in the study based on leaflets and online postings that I have made to publicise the research. My research has been approved by the University of Edinburgh Research Ethics Committee in the Centre for Population Health Sciences.

What would taking part in the research involve?

I would like to carry out three interviews with you; one in the first trimester, at around 10 weeks (before your first trimester scan), one in the second trimester (13-27 weeks), and one in the last trimester of pregnancy (28-42 weeks). These interviews will last for around one hour, and will be audio-recorded with your permission. You will be able to choose a suitable time and location for the interview to take

place. During interviews we will discuss your experiences of your changing body, the technologies you encounter and your appointments with health professionals.

What will happen to the information you collect about me?

With your permission, I plan to record the discussions using a digital recorder. I will type up the interviews on a password protected computer, and destroy all recorded material at the end of my PhD (expected to end in October 2015). Written transcripts may be archived for use in future research. I may use quotes from the discussions in my research, but will not use any personal details. Any names included in the study, including your own, will be changed. Consent forms will be kept separately and securely from the recordings and transcripts, and destroyed at the end of my PhD.

Are there any benefits to taking part?

There is no financial benefit to taking part in this research, however, it is hoped that you will find it enjoyable to share your experiences of pregnancy, and that the results of this study could contribute to improved services and antenatal advice for pregnant women.

Are there any disadvantages to taking part in this research?

It is expected that the three interviews will each take around an hour of your time.

Do I have to take part?

You do not have to take part in this research. If you do decide to take part, you are free to leave at any time. If, for any reason, you would not like to be contacted by me again, please let me know. You, your partner, or a friend or family member (providing your name), can simply email or text me saying 'opt out' (details below). You don't have to give a reason. I will also provide you with a stamped envelope with my postal address at the first interview, if you would prefer to do this by post. If you do not want me to use anything you say in the research, please let me know.

If you have any questions before or after any of the interviews, please feel free to contact me: pregnancy.study@ed.ac.uk. My telephone number is xxxxxxxxxxxx.

APPENDIX VI

Consent form (presented to participants before first interview, and signed at first interview)

'Exploring experiences of pregnancy' PhD study
Emily Ross, Centre for Population Health Sciences, The University
of Edinburgh
pregnancy.study@ed.ac.uk

Consent Form

*Please **initial** the boxes and sign the form below if you consent to take part in my research:*

I have read the information sheet for this study, and consent to take part in the research

☐

I understand that the interview will be recorded, but that I am free to leave the interview, or ask that the recorder be switched off, at any time.

☐

I understand that quotes from the discussion may be used in the student's research, but that no personal details will be used in the final project.

☐

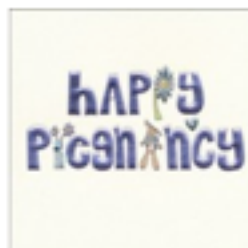
I understand that taking part in the research is voluntary, and that I can withdraw at any time.

☐

Your name:.....

Signature:.....

Date:.....



APPENDIX VII

Timeline of technological interventions received during 'low risk' pregnancy
Adapted from *Your Guide to Screening Tests during Pregnancy* (NHS Health Scotland, 2014: ii)

Week	Screening test(s)
0-10	Blood test for sickle cell and thalassemia
8-12	Blood tests for haemoglobin, blood group and Rhesus antibodies Blood tests for infectious diseases including hepatitis B, HIV and rubella susceptibility
11-14	Early blood test for Down's syndrome
11-14	Early pregnancy scan. Nuchal translucency test for Down's syndrome (this is often incorporated into the scan)
14-20	Later blood test for Down's syndrome, if earlier test is not performed.
18-21	Foetal anomaly scan ('mid-pregnancy scan')

APPENDIX VIII
Interview Topic guide: Trimester 1

Trimester 1

Areas to cover;

1. technologies/artefacts experienced eg tests/books, discourses shaping women's experiences of early pregnancy (e.g. risk, motherhood)
2. discourses shaping women's experiences of early pregnancy (e.g. risk, motherhood), embodied experience of pregnancy (may not yet be any experience of the fetus), transforming subjectivity.
3. any initial thoughts towards/about fetus
4. sources of advice and how these are regarded

Interview questions

Take me back to the beginning of your pregnancy; please tell me about this...

- Suspecting a pregnancy: some women say that they knew they were pregnant before taking a test, what are your experiences of this?
- Taking the test: I've heard stories about women taking more than one test, what was your experience?

Please tell me about what happened once you found out you were pregnant?

- Sharing news: Tell me about your experience of sharing the news with others – who did you tell?
- Visit to doctor: Tell me about what led you to go to the GP. What happened during your first meeting; what did they say? What would you have liked to have happened?
- Have you had the booking appointment?...when did you have it, what did they ask you? Why did they ask these things? What tests did they do? What are they for? How did the tests make you feel about the pregnancy?
- Please tell me about what will happen next. (What kinds of tests are you expecting to have? How do you feel about them? Do you think you will have the tests?)

This may seem like a silly question, but as I have never experienced pregnancy, could you tell me about what it is actually like to be pregnant?

- Are you enjoying the pregnancy so far?
- Did you have expectations about what it would feel like?
- Please explain whether you feel like you should be feeling a certain way? (about the pregnancy?)
- Some people have told me that they sometimes forget they are pregnant, what are your experiences?
- Do you still feel like you? Or different? Please tell me about how you feel...

Maybe you don't think about it, but if you do, please tell me about what you imagine is going on inside you?

- Some people have told me they look at diagrams of development, what are your experiences?

How do you feel about sharing news of your pregnancy with others? Why?

- Some women have said they did not tell friends/family until after 1st trimester; what do you think about this/why do you think this is?
- Some women find that their experience of pregnancy is different once they tell other people they are pregnant; please tell me your thoughts about this...
- How do you feel about discussing your experiences of pregnancy with your partner?

Do you think that your life has changed at all since finding out you are pregnant?

- Please tell me about any changes you have made since you found out that you were pregnant...why have you made these changes?
- Please explain whether any of the changes to your body caused by pregnancy have changed your daily life
- Have there been any challenges?

Have you thought about the rest of your pregnancy? What do you imagine it will be like?

- Are you are looking forward to it?...
- Have you thought about your 12 week scan?
- Please tell me about anything you are not looking forward to...(worries/concerns)

It seems to me that there is a lot of advice available to pregnant women, what are your experiences of this?

- Some people seek more advice than they receive from the GP/midwife; please tell me about your experiences of this
- How do you feel about all this advice? (good/bad thing; trust it? Will follow it?)
- Please tell me about why you intend to follow/not follow this advice
- I have seen that there are loads of supplements and things that you can buy for pregnancy; please tell me about your experiences of these.

Is there anything you wanted to discuss that I haven't asked you about?

Please fill in the demographic information

Appendix VIII

Interview Topic Guide: Trimester 2

Trimester 2

Things to cover; technologies/artefacts experienced eg tests/books, sources of advice and how these are regarded, thoughts towards/about foetus, any experiences of a bond, discourses shaping women's experiences of pregnancy (e.g. risk, motherhood), embodied experience of pregnancy (eg swelling body), embodied experience of fetus, subjectivity.

How have you have been since we last met?...

- Do you still feel nauseous?
- Do you think there have been any changes happening in your body? How do you feel about them?
- Have you had to buy different clothes?
- Do people notice you are pregnant? Has this changed your experience of being pregnant?
- Have you told more people about the pregnancy? Has this altered your experience of being pregnant?...
- Have there been any other changes in your life; e.g. work or family?

(I am not sure what happens during the scan) Please tell me about your experiences of the 12 week ultrasound scan...

- How did you feel in the run up to the scan? I remember you saying you were a bit nervous about it
- Do they explain why they do the scan?
- Please talk me through the ultrasound scan (How did you feel about it in the run up to the appointment? what happened when you got there/ what did they say to you? What did it feel like? Did you see the image straight away? What did the sonographer say? What did they point out? What did your partner say? What did you say? How did you feel during/after the scan?)
- Please tell me about any images of *your* body that you saw/were shown on the scan. How did this feel?
- Were you given any images at the scan? What have you done with them?

Please tell me about any other appointments you have had with health professionals...(16 week midwife appt.)

- Please tell me what kinds of questions they ask you...
- Please tell me about the advice they have given you...

- Please tell me about your experiences of any tests (blood tests/urine tests/heartbeat monitor) – what are they for? How do they make you feel about your pregnancy?
- What do you think about the information they have given to you? (do you trust it?)
- Please explain whether the things they tell you fit with your experiences of pregnancy – is it easy to follow?
- Please explain whether you happy with the number of times you see the midwife...
- Do you get information about pregnancy from other sources (partner, friends, family)?

You're in the second trimester now, does it feel different from the first?...

- You said you were feeling tired when we last met, are you still feeling tired or sick?
- Do you think of your pregnancy in terms of trimesters?
- Do you feel the any differently about the pregnancy from the first trimester/when we last met?
- Please tell me about any times when you forget you are pregnant this trimester...what kind of things make you remember?
- Are you/will you do any antenatal or exercise classes do you think? Why?

Do you think about what is going on inside you?

- Do you think about how it is positioned? Can you show me?
- Do you think about what it looks like? Are you still getting the updates on your phone/email?
- Have you felt any movements?
- I imagine it must be difficult to describe, but can you try and explain what movements feel like? Do they make you feel differently about pregnancy? How do you feel about them? e.g. like or don't like them
- Do you do anything to interact with the baby?
- Do you feel like you should feel a certain way about pregnancy/the baby? where does this come from?

Next appointment will be the 20 week scan; how are you feeling about it?

- Do you think you will find out the sex? Why/why not?

Do you think about the fact that you will have a baby?

- Please explain anything you are concerned about
- Please explain anything you are looking forward to

- Have you had any guesses about the sex?
- Have you made any preparations e.g. bought anything baby-related? Other plans for future – housing/work

Please tell me about your relationships with others now they know that you are pregnant...

- Have any of your family relationships changed in any way?
- Have you had any questions? Who do you ask for advice?
- Do others ask you questions about pregnancy? What?

Please tell me what you imagine things to be like in the third trimester? Anything you are looking forward to/not looking forward to?

Is there anything you wanted to talk about that hasn't come up?

APPENDIX X

Interview Topic Guide: Trimester 3

Trimester 3

Things to cover; technologies/artefacts experienced eg tests/books, sources of advice and how these are regarded, thoughts towards/about foetus, any experiences of a bond, discourses shaping women's experiences of pregnancy (e.g. risk, motherhood), embodied experience of pregnancy (eg swelling body, moving organs), embodied experience of fetus, return to pre-pregnancy subjectivity.

Tell me about how you have been since we last met...

- How has your body changed since we last met?...How have you found these changes? (Have any of these changes been uncomfortable?)
- Now that you are visibly pregnant, how has this changed your experience of pregnancy and your life in general?
- Have you had to buy different clothes?
- Have you had any experiences of people treating you differently? Please tell me about them...

Can you tell me about how it feels to be pregnant in the third trimester...

- Do you feel like you should feel a certain way about pregnancy/the baby? where does this come from?
- Please tell me about how you imagine the baby/foetus this trimester (what do you imagine it to look like)? Do you think about how it is positioned? Please show me...do you think about what it is doing?
- I imagine that now the baby is bigger, your experiences of movement might be different, please tell me about the experiences of movement you feel this trimester. How do you feel about them?
- Please explain to me what your health prof. tells you about movements this trimester (I heard that health professionals say you should feel a certain number of movements; what do you know about this? How does this make you feel?)

Please tell me about your experience of the 20 week ultrasound scan:

- Please explain to me the purpose of the second ultrasound scan
- Please talk me through the second ultrasound scan (what happened when you got there/ what did they say to you? What did it feel like? What did you see? What did the sonographer say? What did they point out? What did your partner say? What did you say? How did you feel during/after the scan?)

- Please tell me about what you have done with any images you received at the scan
- Please tell me about your feelings about the second scan compared to the first scan.
- Please explain whether you would have liked more/less scans.
- *Please tell me about any other technologies you would like to have used during pregnancy, even if they are not real ones.*(e.g. test to detect amniotic fluid/urine, birth date predictor.)

Please tell me about the other appointments you have had with health professionals this trimester...

- (are you seeing them more/less often?)
- Please tell me about your experiences of any tests (blood tests/urine tests) this trimester – what are they for? How do they make you feel about your pregnancy? The baby?
- Have you had experiences of any technologies this trimester e.g. scan/heartbeat monitor – how do these make you feel about the pregnancy? The baby?
- Has the midwife been measuring you this trimester? How do you feel about this?
- Has she started to feel for the baby's position? Do you like that it is done this way? (All other measurements seem very technological) – (would you prefer a scan maybe?)
- Please tell me what kinds of questions they ask you...
- Please tell me about anything you haven't told them...
- Please tell me about the advice they have given you this trimester...
- What do you think about the information they have given to you? Do you follow it? – please tell me how this has changed since last trimester
- Are you following advice in the same way as at the beginning of pregnancy?
- Please explain whether the things they tell you fit with your experiences of pregnancy
- Please explain whether you happy with the number of times you see the midwife...
- Please tell me about your use of other sources of information about pregnancy this trimester...(have you bought any books?)
- If there are any, please tell me about any pregnancy classes or services you make use of...

How do you feel about the fact that you will soon have a baby?...

- Please explain anything you are concerned about
- Please explain anything you are looking forward to

Please tell me how you feel about the fact that you will soon no longer be pregnant.

If you have any, please tell me about any sort of connection you have felt towards the baby this trimester...

- Has the way you feel about the baby changed from first trimester/second trimester – how? What caused this change?/ Where do you think these feelings come from?
- Please tell me about anything you have done to interact with the baby this trimester
- Please tell me about anything your partner or others do to interact with the baby this trimester.
- Please tell me your experiences of preparing for the baby this trimester (e.g. buying items)...
- Do you see the baby as separate from you or connected to you (placenta)? Please tell me how you imagine the food/drink you consume to affect the baby...
- *I know you didn't have the best time at the beginning of the pregnancy. If someone said to you 'we can put the fertilised egg in an artificial womb and grow it there', instead of in your body, would you have said yes? Why/why not?*

Please tell me about your relationships with others now that you are visibly pregnant...

- Please tell me how you feel now that your pregnancy is very public (no longer only you and few others knowing?)
- Some women have said that once visibly pregnant, strangers have started to speak to them about the pregnancy or touch their belly. What are your experiences of this?
- Have you formed new relationships with others since becoming pregnant? (online, antenatal classes)

Why did you want to take part in the study?

Is there anything you wanted to talk about that hasn't come up?

APPENDIX XI
Extract from research diary

31st January 2013 – Following my first interview with Caroline

A great interview, some ‘golden quotes’, and really got on well with Caroline. She was nervous at first. She said she was a nervous person, which did come across in the interview (as she predicted).

I was surprised at how open she was with me about her life – she gave a large amount of detail about her medical history and family. But great that she felt she could be open. This may have had something to do with the setting – I chose a position far away from other tables.

After the interview, and after I had turned the recorder off, the atmosphere totally changed. I felt it needed to. She chatted more about relevant experiences, including her past reproductive history. I have decided not to include in my thesis due to this information being divulged off-tape. She also described using ovulation monitors.

At first she couldn’t really look at me when speaking to me, but she relaxed as the interview progressed. Wanted to know if I would use anything that could identify her, I explained that I would delete names and places, and to let me know if there was anything in particular she wanted me to omit.

I found, as in other interviews, and that I reassure women during our discussion, especially by telling them about the experiences of others. Perhaps she experienced the interview as therapeutic?

After the digital recorder was switched off, we also talked about a discrepancy regarding due dates.

6th February 2013

Turning the tape recorder off – I feel it breaks a tension. Even though women seem relaxed during interview, and open, something changes when I say “I’ll turn this off now”, and put it away. I am unable to audio record new things that may be said, but perhaps wouldn’t have arisen if the tape recorder was left on? Must write them down!

APPENDIX XII

Listening Guide originally developed for analysis

Listening Guide (adapted from Brown and Gilligan, 1992; Mauthner and Doucet, 1998 and Gilligan et al, 2003)

Reading 1a) Reading for the plot

This is to get a sense of what is happening to the participant. The researcher must follow the unfolding of events the participant describes

- What is the story they are telling?
- What are the main events, who are the protagonists, and are there subplots?
- Listen for recurrent images, words, metaphors and contradictions in this narrative.

Reading 1b) Reading for MY responses to the narrative

Reflect on researcher's privileged position, interpreting the life events of another, and consider the implications of this act. The researcher must identify and explore their own feelings and thoughts about the interviewee and her story;

- In what way do I identify with or distance myself from this person?
- In what ways are our experiences different or the same?
- Where am I confused or puzzled? Where am I certain?
- Am I upset or delighted by the story, amused or pleased, disturbed or angered?
- Mauthner and Doucet (1998) also suggest reflection on the researcher's theoretical location; how does this influence interpretations and conclusions?

Reading 2) Reading for the voice of the 'I'

This is important to understand how the respondent speaks of herself before we speak of her; an attempt to include the voice of the respondent in our description of her.

- How does the respondent experience, feel and speak about herself?
- Pay attention to where the respondent uses personal pronouns such as 'I', 'we' or 'you' in talking about themselves; may signal changes in how the respondent perceives herself
- Does this change over the course of the interview, or subsequent interviews?

Reading 3) Reading for relationships

Attend to the ways participants talk about relationships - how they experience themselves in the relational landscape of human life.

- Listen to how respondents talk about interpersonal relationships with their partners, their relatives, and the broader social networks within which they live and work.

Reading 4) Placing people within cultural contexts and social structures

Look for broader social, political, cultural and structural contexts surrounding participant, and felt societal pressures.

- Dominant discourses of motherhood and moral language in relation to this 'should', 'shouldn't', 'right', 'wrong'
- Experience of being at work/taking maternity leave while pregnant
- Encounters with medical profession – authoritative knowledge?

APPENDIX XIII

Amended Listening Guide eventually used in analysis

Listening Guide II (adapted from Brown and Gilligan, 1992;
Mauthner and Doucet, 1998 and Gilligan et al, 2003)

Reading 1a) Reading for the plot

This is to get a sense of what is happening to the participant. The researcher must follow the unfolding of events the participant describes

- What is the story they are telling?
- What are the main events, who are the protagonists, and are there subplots?
- Listen for recurrent images, words, metaphors and contradictions in this narrative.

Reading 1b) Reading for MY responses to the narrative

Reflect on researcher's privileged position, interpreting the life events of another, and consider the implications of this act. The researcher must identify and explore their own feelings and thoughts about the interviewee and her story.

- In what way do I identify with or distance myself from this person?
- In what ways are our experiences different or the same?
- Where am I confused or puzzled? Where am I certain?
- Am I upset or delighted by the story, amused or pleased, disturbed or angered?
- Mauthner and Doucet (1998) also suggest reflection on the researcher's theoretical location; how does this influence interpretations and conclusions?
- Where do I [unnecessarily] influence participants' responses (e.g. leading questions, terms used)?

Reading 2) Reading for the foetus

This is important to understand how the respondent speaks about the foetus; this *may* provide a reflection of whether and how they conceptualise the foetus as a person and if/how this changes over time

- How does the respondent experience, feel and speak about the foetus?
- Pay attention to where the respondent uses personal pronouns such as 'he/she' or impersonal terms e.g. 'it' in talking about foetus; may signal changes in how the respondent perceives the foetus
- Does this change over the course of the interview, or subsequent interviews? Link to reading 1a – what events correspond with changes in discussion of foetus?

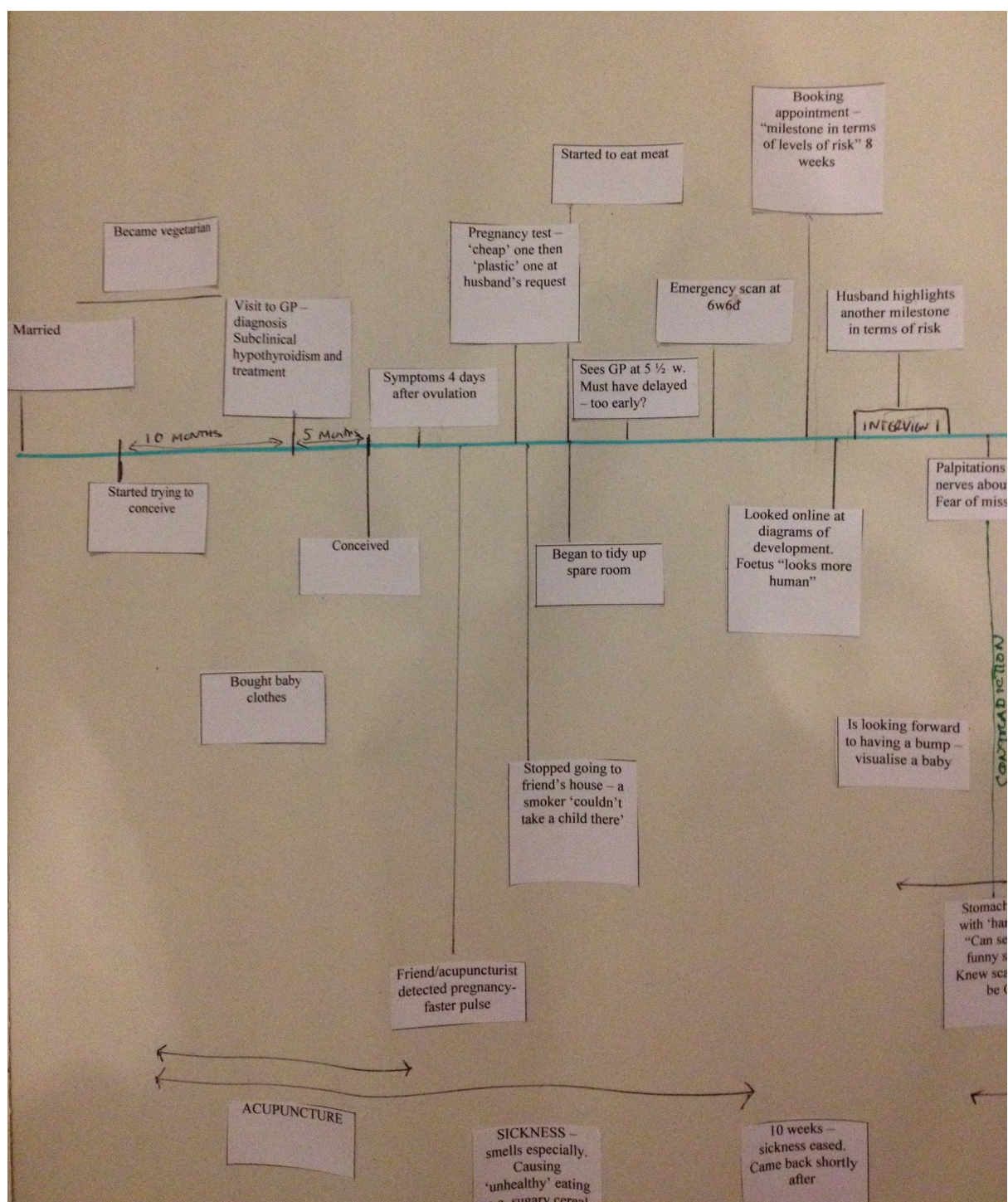
Reading 3) Reading for relationships, cultural contexts and social structures

Look for broader social, political, cultural and structural contexts surrounding participant, and felt societal pressures.

- Dominant discourses of motherhood and moral language in relation to this 'should', 'shouldn't', 'right', 'wrong'
 - Encounters with medical profession – authoritative knowledge?
 - Attend to the ways participants talk about relationships - Listen to how respondents talk about interpersonal relationships with their partners, their relatives, and the broader social networks within which they live and work.
-

APPENDIX XIV

Example of timeline developed during reading 1



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